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FEBRUARY, 1961

Journal of



The Canadian Hospital Association

Canadian Hospital



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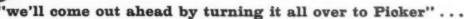
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CANADIAN HOSPITAL



THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

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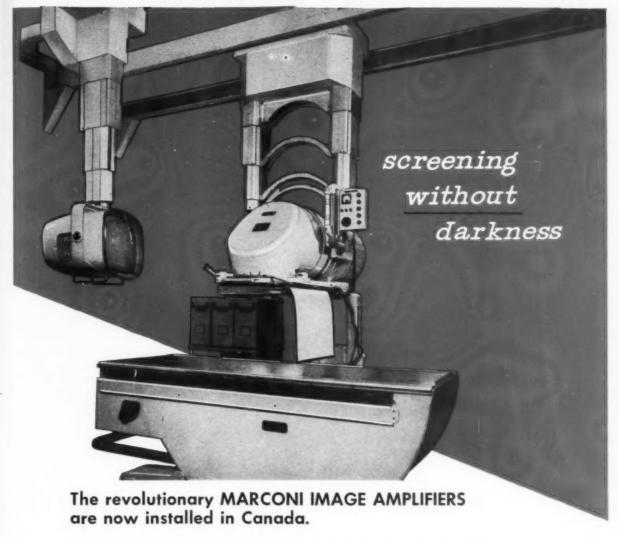
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notes about people

Administrator Appointed at Ross Memorial Hospital

Eric Freeborn has been officially appointed administrator of the Ross Memorial Hospital in Lindsay, Ontario. Mr. Freeborn has filled the office of acting administrator since last summer when George S. Dixon resigned. Prior to accepting this position, Mr. Freeborn had been business manager at the hospital for the past three years. A native of Bobcaygeon, Mr. Freeborn was educated in Toronto and at the University of Chicago, where he obtained a C.A. degree.

At Jewish General

Norman J. Nadler, M.D., assistant physician in the department of medicine at the Jewish General Hospital, Montreal, P.Q., has just been given two promotions. The first is the post of physician-incharge of the hospital's diabetic service; the second, a promotion at the faculty of medicine, McGill University, where he was named

an assistant professor in the department of anatomy.

Under the direction of Dr. Nadler, a diabetic day center, which has been operating mainly for private patients at the hospital, will be expanded to accommodate patients from the out-patient clinics. All new-found diabetics will receive ambulatory treatment and education which will enable them to control their condition.

At the same hospital, Max Shainblum, former personnel manager of an industrial firm, has been appointed personnel officer. He replaces André Dumais who resigned recently.

Flin Flon Appointment

H. F. Silversides has accepted the post of executive director of the Health Association of the Hudson Bay Mining Company in Flin Flon, Man. The new post entails the managing of the health plan of the Employees' Health Association, two hospitals and a large clinic.

Prior to his appointment Mr. Silversides was administrator at Cornwall General Hospital, Cornwall, Ontario, for the past two and a half years.

Appointment at R.V.H.



John S. Astle, formerly purchasing agent at the Royal Victoria Hospital in Montreal, P.Q. has been appointed assistant controller and chief accountant at the hospital.

New Director Named for Tbc. Hospital

G. E. Maddison, M.D., director of tuberculosis control for New Brunswick since 1947, has been appointed medical superintendent of the Saint John Tuberculosis Hospital. Dr. Maddison succeeds Dr. L. Macpherson who is retiring after 31 years of service with that hospital. Mrs. Macpherson, who as Dr. Irene V. Allen has been a member of the hospital medical staff for 29 years and assistant to her husband during his term as medical superintendent, has also resigned.

Record Librarian at Grande Prairie Hospital

The Grande Prairie Municipal Hospital has added a medical record library and an experienced librarian to head it. Frederick T. Taylor has had extensive experience in documentary and administrative work in military hospitals in Europe as well as on this continent—Whitehorse, Yukon Territory and Toronto. Mr. Taylor assumed his new responsibilities in January.

• Sister Mary Frederick of St. Michael's Hospital, Toronto, Ont., assisted by Nan Tupper Chapman of the Sanitorium Board, Winnipeg, Man., will preside over a round-

(concluded on page 24)

Blue Cross Thrives in Canada



John N. Flood

The annual meeting of the Canadian Council of Blue Cross Plans was held at the Queen Elizabeth Hotel, Montreal, in November of last year, with a full representation present from the Canadian Blue Cross Plans (Alberta, Ontario, Quebec and the Maritimes).

All plans were able to report successful operation over the past 12 months. It was evident that those plans offering coverage for preferred accommodation in provinces where there is governmentsponsored hospital insurance were doing particularly well. Certain plans have also had some success in offering coverages in the medical or extended health care field.

Recent changes in the structure of the Blue Cross Commission and the relationship of the Canadian plans with the American Hospital Association and the Blue Cross Association were examined in detail. It was learned that all Canadian plans had decided to become associate members of the Blue Cross Association, as well as retaining associate membership type IV in the American Hospital Association.

The Council received a report on current activities of the Canadian Hospital Association and, in view of the continuing financial need, extended to that organization a grant of \$1,000 for this year.

Officers of the Council elected for the ensuing 12 months are: president—John N. Flood, Saint John, N.B.; vice president—J. A. Monaghan, Edmonton, Alta.; and secretary treasurer—S. W. Martin, Toronto, Ont.



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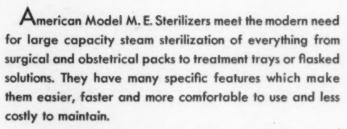
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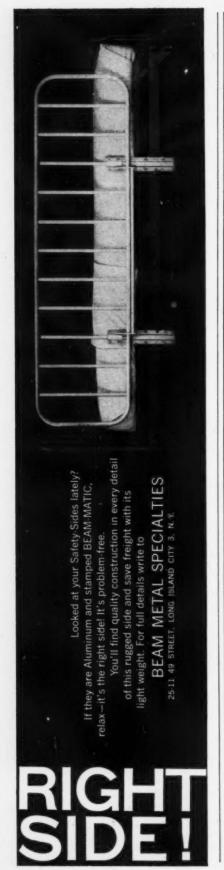
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- Feb. 27-March 3—Purchasing Institute, co-sponsored by A.H.M. and C.H.A., Winnipeg, Man.
- March 3—Canadian Nurses' Association—Canadian Hospital Association
 Joint Committee Meeting, Nursing Unit Administration,
 25 Imperial Street, Toronto, Ont.
- March 4—Canadian Hospital Association Committee on Education, 25 Imperial Street, Toronto, Ont.
- Mar. 17—Meeting of the Executive Committee, Canadian Hospital Association, 25 Imperial Street, Toronto, Ont.
- Mar. 18—Meeting of the Board of Directors, Canadian Hospital Association, 25 Imperial Street, Toronto, Ont.
- March 22-24—American College of Hospital Administrators Regional Members Conference, Macdonald Hotel, Edmonton, Alta.
- April 4-7—Maritime Hospital Association Institute on Administration, Moncton, N.B.
- Apr. 19-21-Quebec Hospital Association, Montreal, Que.
- Apr. 27-29—Canadian Physiotherapy Association Congress, Queen Elizabeth Hotel, Montreal, P.Q.
- May 1-5—American College of Hospital Administrators, Second Canadian Advanced Institute, Royal York Hotel, Toronto, Ont.
- May 24-26—Canadian Hospital Association Assembly Meeting, Park Plaza Hotel, Toronto, Ont.
- May 26-27—Catholic Hospital Association of Canada Biennial Convention, Montreal, P.Q.
- June 2-5—Canadian Public Health Association, University of Saskatchewan, Saskatoon, Sask.
- June 5-9-Maritime Hospital Association, Nova Scotian Hotel, Halifax, N.S.
- June 5-9—12th International Hospital Congress, Island of S. Giorgio Maggiore, Venice, Italy.
- June 5-29—Hospital Organization and Management Summer Session, Winnipeg, Man.
- June 12-15—Catholic Hospital Association of United States and Canada, Detroit, Mich.
- June 12-16—25th C.S.L.T. Convention, Royal Alexandra Hotel, Winnipeg, Man.
- June 19-23—Canadian Medical Association, 94th Annual Meeting, Queen Elizabeth Hotel, Montreal, P.Q.
- June 20-23-Western Canada Institute, Saskatoon, Sask.
- June 23-29—Third International Convention of X-ray Technicians, C.S.R.T. and A.S.X.T., Queen Elizabeth Hotel, Montreal, P.Q.
- June 25-July 21—Fourth Annual Hospital Administrators Development Program, sponsored by The Sloan Institute of Hospital Administrators, Cornell University, Ithaca, N.Y.
- June 26-28—Comité des Hôpitaux du Québec Convention, Montreal Show Mart Inc., Montreal, P.Q.
- Sept. 10-14—International Tuberculosis Conference, Royal York Hotel, Toronto, Ont.
- Sept. . . . —British Columbia Hospitals' Association Convention, Vancouver, B.C.
- Sept. 25-28-American Hospital Association, Atlantic City, N.J.
- Oct. 3-5—Manitoba Hospital and Nursing Conference, Royal Alexandra Hotel, Winnipeg, Man.
- Oct. 8-9-Catholic Hospital Conference of Alberta, Calgary, Alta.
- Oct. 10-12-Associated Hospitals of Alberta Convention, Calgary, Alta.
- Oct. 23-25-Ontario Hospital Association, Royal York Hotel, Toronto, Ont.



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FEBRUARY, 1961

23

People

(concluded from page 14)

table workshop on hospital feeding at the annual convention and exhibition of the Canadian Restaurant Association, held on March 22, at the Automotive Building, Exhibition Park, Toronto, Ont.

• Hélène Nussbaum has been appointed to succeed D. C. Bridges as general secretary of the International Council of Nurses in April of this year. Miss Nussbaum has

for the past two years been executive secretary of the Swiss Association of Graduate Nurses. Her knowledge of languages and her varied experience in nursing will be of great help in her new position.

◆ A. F. Fowler, M.D., associate director of the Montreal General Hospital's metabolism and toxicology departments, has also been appointed director of the hospital's new sub-department of diabetes and endocrinology.

• Jean-Marie Lapointe, employed by the l'Hôtel-Dieu St-Michel in Roberval, P.Q., in various departments for the past seven years, has been promoted to the position of personnel manager at the hospital and the St-Michel Sanatorium as well.

• Formerly administrative officer at Sunnybrook Hospital in Toronto, Ont., R. A. C. Renny has taken the position of administrator at the Sensenbrenner Hospital in Kapuskasing, Ont., as of December, 1960.

• Nathan B. Epstein, M.D., has been appointed psychiatrist-in-chief of the Jewish General Hospital, Montreal, Que., whose mental health department has been placed on a full-time basis. He succeeds Dr. Saul Albert.

● Douglas M. McNabb, former administrator of the Emma L. Bixby Hospital, Adrian, Mich., has accepted the position of administrator of the Parma Community General Hospital, Parma, Ohio, which is to be completed in June of this year. Mr. McNabb is a graduate of the University of Toronto.

Hospital for New Waterford, N.S.

Construction has started on a 100-bed general hospital and nurses' residence in New Waterford, N.S. (See cover). This \$1,400,000 structure was designed by Keith L. Graham of Halifax. It is hoped that the hospital and nurses' training centre will be ready for service early next year.

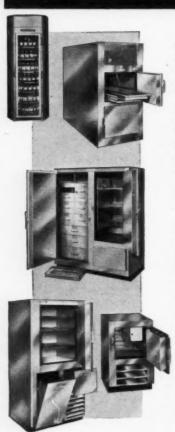
The hospital proper will have three floors, excluding the basement and penthouse. It is "T" shaped with a frontage of 263 feet. The nurses' residence is connected to the hospital by a covered walk above ground level. A reinforced concrete structure is the hospital's engineering feature which affords fireproof building material without laborious, expensive fireproofing applications that are required when steel is used.

The hospital, which is to serve the surrounding area of New Waterford, is owned by the New Waterford Consolidated Hospital Commission, composed of town councillors, representatives of the county and the Salvation Army. The Order of the Sisters of St. Martha will operate the institution.

The man who watches the clock generally remains one of the hands.

—Journal of Phi Rho Sigma

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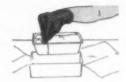
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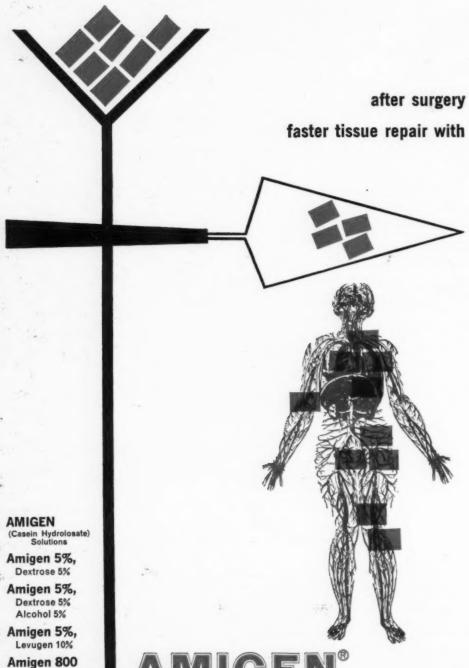
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EDITORIAL

It Could Happen to You

A REVIEW of convention topics during the past two years will show that the subject of public relations is one that is featured at practically all meetings. The need for hospitals to become more active in this area was pointed up by the Hon. J. Waldo Monteith, Minister of National Health and Welfare, in his 1960 address to the Canadian Hospital Association Assembly. The Minister said:

"To me, it simply means that hospitals have more to do in getting their case across to the people they serve. In other words, they should step up their public relations efforts. I am aware that increasing attention is being given to this matter, but I feel that it merits even greater emphasis in view of the introduction of the hospital insurance program. The further extension of provincial and federal responsibility has tended, I am afraid, to reinforce the existing public indifference to hospital affairs. It is even easier now for the average citizen to shrug his shoulders with the idea that the government will take care of everything. This obviously is not the case nor is it desirable that it should be. The very foundation of democratic society rests on a high degree of citizen understanding and support of its various institutions. Hospitals are no exception. In fact, they require not only citizen understanding and support but also citizen participation in their programs and services. In my view, the attainment of this objective—the bridging of the gap between hospital and community-is the number problem facing members of this association today. It is moreover a problem which only you yourselves can meet. But, if the challenge is great, so is the reward which success will bring. Indeed, few endeavours in the long and distinguished history of Canadian hospitals have held out brighter prospects for continued progress and achievement.'

Text books on public relations point out that to have a successful program, it is essential to keep your staff in mind. Public relations start with your own staff—their attitude towards the hospital and their understanding of its aims and objectives.

Recently, an administrator in a 200-bed hospital, who was keen on developing a public relations program, decided to start with his staff. He tested a segment as to their knowledge of their own hospital and their attitude towards it. Questions were drawn up and a number of employees were interviewed by an outside observer on an informal basis. Discussions between the observer and employees were recorded on a tape, (See page 47) the employee remaining anonymous. When this material was analyzed, the administrator was amazed at some answers. For example, one employee's answer to "Why are hospital costs so high?" was "If you saw all the food that is wasted around here, you would know why." We do not know whether this bothered him so much as the answer to "What is the name of the administrator of this hospital?" which was "I do not know."

With regret, we do believe that these results are typical. We believe it could happen even in smaller hospitals. If you doubt this assertion, perhaps it is worth your while to test it for yourself.

The lesson surely is that we cannot afford to take anything for granted. Each departmental head and each administrator should work out his or her own system of disseminating information to the hospital staff. If we think about it, various methods suitable to each situation will come to mind. Then, if translated into action, a start can be made.

W. Douglas-Piercey

Physiotherapists Needed

MOST of us in the hospital field are aware of technical personnel shortages in various departments. Few of us are in a position to confer, on a national basis, with others who have similar problems in obtaining properly qualified people. The Canadian Hospital Association is a member of a Planning Committee that is arranging a one-day conference on May 1, in Toronto to explore the needs and problems as they relate to physiotherapy.

Nearly 50 representatives of the physiotherapy profession, university medical schools, government departments, voluntary agencies, and hospitals will discuss problems relating to this field. Early in January this association mailed over 500 survey forms to hospitals in Canada. This survey will help indicate the present staffing situation and also assist in determining future needs.

Following the conference, a Select Committee will prepare a report and offer recommendations to relieve the present shortage of physiotherapists. It is our belief that, unless steps are taken to increase professional training facilities and thus increase the supply of physiotherapists, there is a very real danger that the provision of medical rehabilitation services, necessary for the disabled and chronically ill, will be seriously jeopardized. We look forward to a productive conference and the opportunity to bring you the results of this meeting through the pages of this journal.—L.L.W. (See also page 82).

Bill 320 Now Fully Implemented

ON January 1, 1961, the province of Quebec joined with the federal government in providing a comprehensive hospital insurance plan to the residents of that province. Thus, under the terms of the Hospital Insurance and Diagnostic Services Act (Bill 320), the provinces of Canada have now developed, in conjunction with the federal government, a series of insurance plans conforming in general principles but geared to local conditions and practices. While each of the provincial programs differ somewhat in methods and techniques, their purpose is the same.

Aside from certain basic stipulations, the provinces are free to operate and finance their programs as they wish and this divergent pattern is one of the most interesting aspects of hospitalization in Canada. Those of us concerned with hospitals on a national basis sometimes feel that it would be preferable to have a single plan across Canada thus contributing to the simplicity and mobility of hospital insurance coverage. Yet in a larger view this would be a weakness. Canada is a large country with regional differences; and the desires and needs of the people in the Maritimes, for example, are not the same as for those in the prairie provinces. The provision of a single national hospitalization plan would perhaps reduce the difficulties of administration but it would fail in the ultimate purpose of such a plan-the provision of adequate hospital care to the people of Canada.-G. McC.

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The Patient and PROGRESSIVE CARE



H. Bernice Lewis St. Thomas, Ont.

FOR many years the words "patient-centred care" have been familiar to both nursing service and nursing education. This approach to patient care has been the firing-pin for many changes in pattern in the care of the patient. We have seen re-allocation of nursing duties to include the introduction of auxiliary personnel such as the nursing assistant and the ward clerk: total patient care and the team concept of nursing care. We have been altering our plan of teaching in schools of nursing, and our plan of patient care, to provide patient-centred care which would meet the patient's needs on an allinclusive basis of mental or emotional, spiritual, and social, as well as physical.

While we are attempting to meet the patient's needs, it is within boundaries which have been established by hospital policy and traditional methods of hospitalization. Is it meeting the needs of the patient to bring an active man into hospital for diagnostic services, take away his clothes, put him to bed, subject him to bed baths and

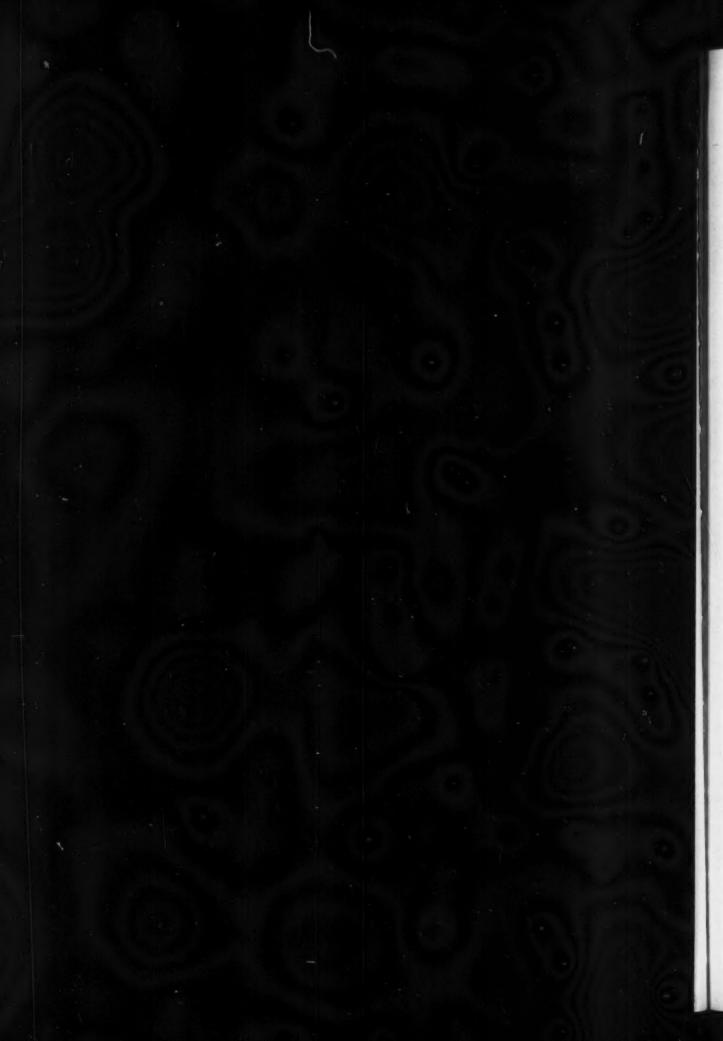
From an address presented at the O.H.A. Convention, October, 1960. The author is director of nursing, St. Thomas-Elgin Hospital, St. Thomas, Ont.

routine nursing care when he is quite capable of looking after himself; e.g., in respect to daily ablutions? Are we not making an invalid out of this patient at an early stage? If we are truly concerned about the emotional needs of the patient, what effect are we producing with this kind of treatment?

We are making every patient a conformist to hospital routine whether he likes it or not. We lower his prestige and take away his individuality. He must go to bed, eat, sleep, and regulate his activities according to an established ward routine. We start him on the road to dependency . . . and think what emotional trauma the independent individual must suffer in these circumstances. Dr. Hans Selye, in his writings on the concept of "stress", states that psychological stress in the form of worry or anxiety may produce tension states resulting in disturbances of bodily function which he terms "diseases of adaptation" To illustrate: we have all heard of patients who have developed symptoms of anxiety after admission to hospital. We glibly erase from our conscience any responsibility for the occurrence by suggesting that the patient was unable to adapt to hospital routine, or that he had some emotional problem related to home and family. How thoroughly do we investigate the situation to see what factors might be involved . . . factors that we could alleviate, e.g., apprehension and fear of the unknown? In what situation could these be any greater than as experienced by the hospitalized individual? He not only doesn't know what the various tests, x-rays, et cetera, may reveal by way of diagnosis but, until he has adjusted to this hospital routine, he doesn't know from one minute to the next what to expect, or what is expected of him. There is no Emily Post ready reference book to help him in his behaviour. He learns by the trial and error method.

What anxiety and stress must be experienced by the patient admitted to a room where a seriously ill or post-operative patient is receiving oxygen therapy, suction, intravenous infusion or blood transfusion? We do not consider how foreboding this unfamiliar equipment must seem to the new patient. No wonder sedatives represent thousands of dollars on our annual pharmacy budgets!





How could one hope to sleep wondering if a similar experience is what awaits him tomorrow or the

next day?

We have sufficient evidence to suggest that we must broaden our concept of "meeting the patient's needs". It is time we studied our whole hospitalization plan as it is related to this concept and what steps might be taken to improve the situation and provide truly patient-centred care.

Such a study has already been undertaken in the United States. Aware that patient care was not meeting the criterion established and from deep concern for improved patient care, several hospitals studied the whole nursing plan, with the emphasis placed on the patient's need for nursing care as related to his or her condition. From this study there evolved a concept called progressive patient care.

What is P.P.C.?

Progressive care may be defined as the organization of hospital facilities and services according to patients' needs instead of by medical departments. There are five divisions of patient care:

1. Special Care or Intensive Care Unit — for patients who are seriously ill and need constant observation for varying periods of time.

2. Intermediate Care Unit — for patients who are ill but not seriously so, and who do not need constant observation.

3. Self Service Unit — for ambulatory patients who need the facil-

ities of a hospital.

4. Continuation Care Unit — for patients who need constant care and rehabilitation for a period of thirty days or more.

5. Home Care—provided through co-operation with other health agen-

cies.

Intensive Care

This unit is designed to relieve the general floors of some of the more critically ill patients and patients requiring close observation, whether it be for 24 hours or for 24 days. These patients, while on the general floors, were requiring more nursing hours (often at the expense of the other patients) than the professional nurse was able to give.

Some hospitals established the unit as a recovery room for surgical patients only, while others included all patients requiring constant nursing care — whether medical, surgical, paediatric, or obstetrical patients. Frequently there was

no segregation of the sexes in the intensive care unit.

It is evident that careful planning is essential for the success of such a unit. Administration, medical staff, and nursing administration should study carefully proposed areas for alteration—physical layout, equipment necessary, and proposed policy including a committee to control admission and discharge in the unit.

Success or failure of this type of intensive nursing service depends almost entirely on the doctors' willingness not only to use the service but to see that patients do not remain longer than necessary. It is the doctor's responsibility to explain the nature of the service to the patient and his relatives.

Personnel Requirements for LC.U.

Personnel must be carefully chosen for this area. Nurses who like bedside nursing, who can calmly and effectively meet emergency situations, and who are alert to change in patients' conditions, are most valuable.

Staffing is simpler in larger wards of 8 to 10 beds and should consist of graduate nurses, nursing assistants, and an orderly when male patients are in the unit. Since this area can provide valuable clinical experience for the student, it is advocated that it be considered special experience in the senior year, and for selected students in the intermediate year.

Numbers of personnel vary with the size of units, and the number of hours of care per patient required. An interesting article entitled "How Many Nurses Are Needed To Staff Progressive Care Units?" appeared in the August, 1960, issue of Modern Hospital.

Where private nursing is required for one patient, the patient is transferred to a private room with special duty nurses. This happens only occasionally; but it does clarify the function of the unit as providing intensive care but not private nursing care to each individual.

Refresher lectures are advisable for personnel in this area, and might include such subjects as head injury routine; diabetic coma and hypoglycemia; shock and hemorrhage; treatment of burns; abdominal and chest injuries; convulsions; acute embolism, coronary, and other heart conditions; anaesthesia and air way; common poisons and antidotes. Familiariza-

tion with the use of equipment for oxygen therapy, negative pressure, parenteral therapy, blood transfusion, and plasma administration is also essential. A review of fluid balance and importance of intake and output should be included.

Patients Eligible for Intensive Care

Policy will necessarily vary with the individual hospital, but that established by one general hospital may be cited as an example. There the presence of any one of the following situations would make the patient eligible for this service: (a) the need to maintain or establish adequate fluid balance and renal function; (b) the maintenance of cardiovascular integrity; (c) the control of toxemia of metabolic or infectious origin; (d) the relief and prevention of severe shock from any cause; and (e) the maintenance or establishment of an adequate air way.

As stated earlier, intermediate care is for patients who are ill but not seriously so, and do not need constant observation.

Self Care Unit

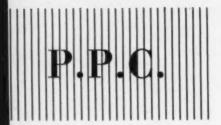
This unit is for ambulatory patients who need extensive tests or are recovering from an illness. It provides an opportunity for teaching patients, adjustment, and transition to the hospital or home environment. The physician, the nurse, and the patient together plan for the patient's future care.

The area designed for the self care unit should be within walking distance for patients going for x-ray, physiotherapy, blood tests, et cetera. There should be a living room with television, reading material, cards, and so on, where the patients gather at will for social activity.

Patients should be allowed to make their own breakfasts if they so desire, and other meals can be taken in the cafeteria, or meals can be sent on a tray to the room where advisable. Patients in this area could also make their own beds and should be encouraged to do all they are capable of doing for themselves.

At Chicago Wesley Memorial Hospital, a ward clerk is on duty at all times, and housekeeping maids are assigned the responsibility of making beds in addition to the housecleaning of rooms. Nursing service is "on call" when required.

It is desirable to remove every-(continued on page 86)



decentralized for continuity

NOT infrequently, hospitals discover that medical staff and nursing staff understanding, integration, co-operation, are not at an optimal working level. Nor are the reasons always apparent. Both medicine and nursing are traditionbound groups, the products of formal training programs. They work in a rigid authority relationship, with the doctor issuing orders and initiating action which the nurse carries out by nursedeveloped routines and methods, often unknown and strange to the doctor. All of this is complicated by quick changes in medical sciences, rapid turn-over of nurses, as well as of patients. A stable, gradually changing situation is the exception, not the rule. When the education of student nurses, medical students, interns and residents is added to this milieu, it is surprising that the system works as well as it does.

Realizing that the quality of medical and nursing service depends to a large extent on the effectiveness of medical-nursing teamwork and knowing that nursing personnel were in short supply, the medical staff of the Winnipeg General established a Nursepower Committee some three years ago. This was later called simply the Committee on Nursing.

Shortly after this committee got under way, word of the progressive patient care concept began to get around this country as well as the United States. We had a postanaesthetic recovery room in service — as the first post-operative area of treatment for most patients. The St. Boniface Hospital, Winnipeg, established a complete post-surgical recovery ward of 25 to 27 beds to provide intensive care to surgical patients in need of a great deal of skilled medical and nursing attention. It was about this time that the United States Public Health Service put out some basic literature on four- or fivestage progressive patient care. This was intriguing, particularly with the articulate and enthusiastic representation of Edward J. Thoms and his staff from Manchester Memorial Hospital, Manchester,

Why then did we not jump into it with both feet? There were a number of reasons at the time, one of them being the generally cautious outlook in Manitoba. Other reasons which bade us make haste slowly were: (a) a large new section of the hospital was built in the standard layout of the past decade - one- and two-bed wards about a ward station; (b) the older section of the hospital lacked many modern services; (c) a medical staff who had not heard much about progressive patient care; (d) a nursing staff of long and honourable tradition, many of whom were the product of the hospital's school of nursing; and (e) a wariness by administration that this concept had not shaken down. L. O. Bradley, M.D. Winnipeg, Man.

So was it wise to commit money to equipment, building and personnel changes, before someone else had done the necessary testing?

But the idea stayed alive. Three of the five stages were available or possible at the Winnipeg General. There were no facilities suitable for self-care and no unit or section for long-term care. It is of interest that both of these are included in plans for the Manitoba Medical Centre of which the Winnipeg General is a member.

Experimental Demonstration

After some months of general discussion, a decision was made to do an experimental demonstration. The teaching medical service showed a real interest and a 33bed male medical ward was selected. The involvement of the medical staff was not difficult since this was a closed teaching ward under the authority of a small number of the attending or active medical staff. A resident in medicine was in charge of all admissions and junior interns were assigned to this ward. The head nurse was particularly suited for the demonstration, being a good leader and organizer, and one who had an open enquiring mind. Opposite the nursing station, an area big enough for about five beds was provided for intensive care. Just next door was a large ward for intermediate care. At

From an address presented at the O.H.A. Convention, October, 1960. The author is administrator, Winnipeg General Hospital, Winnipeg,

the end of the ward were several single and two-bed rooms which might be used for self-care or a variation thereof.

The allocation and movement of patients within the ward was the responsibility of the head nurse acting in consultation with the resident and the attending medical staff. The success of the demonstration was so apparent to all concerned that a decision to extend the demonstration to other areas was made. The original intent was to establish a small intensive care area, depending in size upon demand, in the centre of each ward. It was decided that this demonstration would not extend to orthopaedics, maternity, or eye, ear, nose and throat, since the numbers of seriously ill requiring intensive care and the type of treatment given here did not seem to be suitable to the concept.

Advantages of Decentralization

Continuity of care is the keystone. Continuity in one ward during the active course of the illness is the basis of many of the acceptable features of the decentralized approach. Beginning about 1940, specialization of duties in hospital, and particularly in the department of nursing, began to gather force. First came the removal of the non-nursing duties of housekeeping and dietary service. Then, the growing difference between demand and supply of professional nurses made it necessary to add several categories of nursing help-certified nursing assistants, nurses' aids, operating room technicians, et cetera. The penicillin team, the medication team, the intravenous team, and so on, have been introduced to teach advanced skills to a few in a great hurry. I cannot but feel that the return to the non-specialist will take place in hospitals. In the strange atmosphere of the hospital, the patient looks for a stake or a marker to which he can relate himself. If this marker is moved every two or three days as the patient gets better, the possibility of confusion and uncertainty increases, and the patient may be demoralized.

Several months ago, a clinical instructor was sent to the University of Minnesota Hospital to study the nursing of cardiac patients undergoing surgical treatment. While there, this nurse worked on the ward with a young female patient for several days before surgery. When the patient

Continuity of location contributes to stronger medicalnursing teamwork as both concentrate their skills on the patient. This must be

given a good deal of weight.

woke up in an intensive care unit, away from the ward, she was completely disconcerted because her nurse was not there to attend her. She settled down only when the nurse was quickly transferred to her bedside.

To a patient, the continuity of relationship with "his" nursing staff builds confidence and respect, a very present help in time of trouble. The patient is and remains a personality and not a case to be moved every other day. Nurse and patient come to know one another if there is time. The patient remaining in the ward can see and is more likely to understand and accept the withdrawal of advanced nursing skills and the reduction in the quantity of nursing attention as his needs change.

Relatives Like It

Relatives and friends who were interested in the patient's welfare showed appreciation of the presence and operation of the small intensive care unit on the ward. They came to know the supervisory nursing staff, as well as those who were giving the bedside care. When attention was needed, it was immediately available. Later in the intermediate areas, it was delivered in a more scheduled way. Undoubtedly this feeling of the friends and relatives reflected on the patient. Visitors can come and go without confusion and loss of time if the patient is kept in one spot. This may not be too important in a small hospital where there are only two or three directions to go; but in a larger unit where there may be 10 different ways to get lost, this is very important. The hospital becomes less forbidding and public relations are on a more positive plane.

The Staff Like It

We must be careful, in providing hospital care, to remind ourselves continually that the patient comes first. At the same time, it is true that if the staff like a system, it will be carried out better, and the patient's welfare will indeed come first. The de-

centralized approach to intensive care found favour with all of the categories in the medical care team.

The Doctor

Keeping track of patients, especially in the larger unit, is difficult for the doctor. Even though he is consulted before moving the patient, the transfer means another item for him to remember. The doctor deals with one group of nurses, who come to know the patient as well as he does. This means that many of the pitfalls of communication - of special problems, needs, and peculiarities of the patient — are avoided. This is equally true of the intern and resident staff, particularly when they are allocated on a geographical basis, rather than a preceptor basis which may take them anywhere in the hospital. There may be sound counterargument here, I can see, for the doctor who has a great number of patients in the hospital, and who may have several patients in the centralized intensive care unit at all times. But this is not so for most medical men where there is a large active and courtesy staff.

Nursing

The major gains, it seems to us, come to the nursing team. Supervision is facilitated. With the shortened patient stay, and because of the interruption created by the five day work-week, a head nurse may find a 20 to 25 per cent turn-over in patients following two days off duty. If this turnover is further accelerated by transfer from a centralized intensive care ward or unit, under-standing of the patients' needs, physiological and psychological, are difficult to attain and to retain. Time for communication between nurses on the various shifts and over longer time-off periods increases. Clerical work is increased substantially also.

Where a hospital school of nursing exists, the education of the student nurses becomes an important consideration whenever patterns of patient care are under discussion or revision. The newly graduated nurse should be a well rounded individual who can meet most situations in most hospitals with confidence. The decentralized approach to intensive care involves many graduates in the supervision and instruction of student nurses and other categories of nursing staff. It demands more responsibility and continued learn-

ing, which means that the whole standard of the graduate professional group is constantly being

up-graded.

Underlying this whole approach is the soundness of exposing the staff and the students to the full course of the illness. With specialization, we have tended to fragment the course of the illness to such an extent that the medical and nursing practitioner come to see it in separated or disjointed parts. This may be one reason why we hear more of the impersonality and assembly line atmosphere that some of the public ascribe to their community hospitals.

Other Hospital Staff

One of the by-products of each patient transfer within the hospital is a flurry of paper work. A single location, by this I mean within one ward, means less paper work and more time for patients. It avoids changes at the switchboard, the information desk, mail room, patient information, laboratory specimens, et cetera. This may not sound like much, but when it involves five to ten per cent of the patient population, plus new admissions and discharges, it can add up to a great deal of time and money.

Self-Care is Problematical

The establishment of the selfcare aspect of progressive patient care presents some very engaging problems. Over the years we have carefully conditioned our clientele to a fairly high level of dependent service, e.g. meal delivery, individual or two-bed rooms, beautiful furniture, soft lights, music, television, and a fairly constant level of nursing attention. It was not too difficult to depart from this in the common sense and practical atmosphere of the armed services where you could pull rank on the patient in his shirt-tail and direct him to minister to his own needs, or be without. Looking back at more than five years of war-time service, however, I recall that it was not any easier to get the Brigadier to push a broom than it now is to invite Mrs. Gotrocks to take care of herself.

I do not argue that there is not much merit and common sense in self-care, but it will take all of our salesmanship and persuasion to bring it to pass. We have certain reservations as to whether the self-care phase be situated within the acute general hospital. Our medical staff are insistent that the space be used for acutely ill

patients. The use of adjacent selfcare units undoubtedly has some real advantages. Unfortunately, it is not easy to find the necessary capital funds to build or renovate accommodation and neither Blue Cross nor our government hospitalization plans show much disposition to provide operating funds for the task.

Home Care May Be An Answer

This phase utilizes family resources and demands family responsibility—a worthy principle. It does not require any significant capital expenditure for new facilities since a home provides roof and walls. It does require the interest and participation of the medical profession who, with the family, are offered most of the para-medical personnel and techniques that are available in hospital. It seems to me that our first activity should be here and that the self-care stage might be introduced at a later date.

Are Savings Real?

One of the remarks that is frequently made of progressive patient care is that it may effect a savings in dollars. I am not convinced that it will, and, indeed, I suspect that it introduces the probability of higher cost. If the intensive care phase of progressive patient care is well organized, the need for private duty nursing drops precipitously. The cost of private duty nursing is shifted from a direct professional fee to the patient to become a cost of the nursing department. Nor am I convinced that a total program will effect any substantial savings in the number of professional nurses needed for a hospital of a given size. The primary or actual savings, I believe; are in the effective use of refined and advanced skills in the medical and nursing situations that require them. It does cut across some of the established routines that are or should be in transition if they are to keep up with the increasing complexity of medical care. I do not think that we should talk at all of savings (in money) but rather of the dividends in better patient care.

Where we are talking of the cost of establishing this newly named concept, we cannot avoid looking at the various means of charging for hospital services. There can be little doubt that the all-inclusive rate, with what disadvantages it has, is more satisfactory than the old fee for service method that we used for

years and which is still in vogue in the United States. The all-inclusive method removes the extra monetary consideration from determining when a patient should be moved in or out of the intensive care phase of the program. My recent travels to the United States reveal that all is not well with Blue Cross, the major prepayment agency there, because of the exploding percentage of intensive care days of service that are claimed and charged for in certain hospitals. One person dubbed "intensive patient care" as "expensive patient care"... and so it is.

Not Agin' It

It must seem that my position is against this newly heralded concept of organizing medical and nursing services for patients. This is not so. Some eight years ago, (the late) Gertrude Hall and I planned an intensive care unit and an intermediate care area in one ward at the Calgary General Hospital. It has since been built and is working well.

When we were in the early stages of discussion in the Committee on Nursing at the Winnipeg General, we found that one of our most respected head nurses, who had graduated more than 25 years ago, had concentrated equipment and special care at the centre of the ward and had been moving patients up and down the corridor to facilitate supervision and distribution of service according to need. My position is that it is far too early to accept wholesale full-scale progressive patient care - particularly the location and management of the intensive care phase. We must first gain more experience and carry out some confirming research. We are spending millions of dollars on nursing service but only a few thousand on study and research.

We do now owe the group at Manchester Memorial and the United States Public Health Service a vote of appreciation for bringing about a re-examination of what was going on in our wards and hospitals and for trying to relate the needs of the patient today to the services available to him. We are too prone to preserve the comfort and convenience of the status quo and to avoid the disruption and dislocation which might accompany a new system. We should constantly explore and experiment so that, as a result of the various approaches and disagreements, our patients can expect and profit by better

care.



Architects: Govan, Ferguson, Lindsay, et. al., Toronto.

extended facilities at new Hillcrest

THE Hillcrest Convalescent Hospital in Toronto, one of the first of its type on this continent, is to have an entirely new building, as seen above—increasing its bed capacity from 36 to 120.

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The hospital originated over 70 years ago when a young Englishwoman donated a sum of £2,000, which was \$10,000 then, for the building of a home for convalescent patients, especially the homeless. An acre of land for the building was donated by William Gooderham.

By the spring of 1886 a 21-bed shelter was constructed and while some patients were admitted during that year the hospital was officially opened in May, 1887 by the Governor-General, Lord Lansdowne.

Hillcrest came under the Charity Act in March, 1888, and became eligible for a grant of 15 cents per day per patient which was reduced to 7 cents a day in 1897. In 1892 a new wing was added increasing the accommodation to 54 beds. During its first decade of service the hospital cared for approximately 2,300 patients.

All the hazards and pitfalls of a pioneer venture seem to have been the lot of the home during its first years of service. Financing was difficult, transportation practically non-existent - in 1888 a livery stable was engaged at \$1.00 an hour, to convey board members to meetings, and patients were transported at a lower rate, paid by the board. In 1891 a windmill was built to provide running water. The windmill appears to have been a source of constant trouble for it was on occasion damaged by high winds and at other times failed to operate because there was no wind. Two gasoline engines replaced it in 1908.

One of the most beneficial changes introduced in the hospital, some thirty years ago, was occupational therapy. Patients are still taught such crafts as knitting, sewing, crocheting, embroidery, leather, raffia, and bead

work. In 1937 the annual report mentioned that, in 50 years of service, over 11,000 patients had passed through the hospital.

By 1954, Hillcrest was deemed obsolete and plans were formulated for a new plant. The increase in size is required to help ease the crowding in general hospitals. At the same time Hillcrest is designed to become more active as a rehabilitation centre. The three top floors will have regulation patient space, with solaria and dining rooms for ambulant convalescents. The ground floor will contain a gymnasium, with the equipment required for rehabilitation exercises. Electrotherapy and hydrotherapy are to be provided, as well as speech therapy and extensive occupational therapy. There will also be a terrace for outdoor exercise.

When the new building is completed on the attractive hillside site, the old structure will be demolished. The board is now appealing to the public for funds.

Community Services for the Long Term Patient

There has grown up around the word "chronic" a nasty connotation of hopelessness which puts an undesirable label on both the patient who requires an extended period of treatment and the institution that provides it. In our thinking, we like to use the terms "rehabilitation hospital" and "extended treatment hospital", which seem to offer a psychologically desirable and a constructive approach to the adequate treatment of the long-term patient.

In this article a long-term patient is considered to be one who requires active, regular medical and nursing care for a period of more than 30 days. Because they do not require a hospital service, I shall not discuss the facilities needed for those who require only personal or custodial care, i.e., those, who need assistance in walking and getting out of bed; help in bathing, dressing and eating; special diets; and supervision over medications that can be self-administered. This level of care should be given either in the patient's own home by parents, or other near relatives. Alternatively, this level of care is the proper function of a nursing home.

Types of Hospital Care

To one who has been engaged in the administration of long-stay hospitals for many years, it seems self-evident that this is a field in which the principles of progressive care apply most effectively. With this in mind, I propose to discuss three levels of hospital care needed by the patient with long-term illness or disability.

This is an age of specialization. In industry we take almost for granted that an appropriate subdivision and channelling of effort will bring about higher standards and increased efficiency. Even within the same corporate structure, we

see integrated, specializing entities that not only are separate administrative units, but vie actively with other units in the same enterprise. With hospital activities on the scale they are today, perhaps certain parallels in specialization might be usefully considered.

Hospital operating costs alone in the four western provinces are in the vicinity of 150 million dollars a year-and are constantly increasing. To one who was brought up on a Saskatchewan farm, as I was, this is a lot of money, and I confess that I find it difficult to adjust to the "what's a million" attitude that seems to have developed. It seems to me that hospital people have a responsibility to analyze their operations in a most careful manner, to take a broad view of both patient needs and economic realities, and to consider what developments or improvements in the structure of hospital organization will serve best the interests of both the patient and the community. In the case of patients requiring long periods of hospitalization, I think that special institutions, built and operated at lower cost than general hospitals, designed specifically for the purpose, and serving a regional area, are in the best interest of both the patient and the economy.

Ideally, three levels of hospital care appear to be needed by the long-term patient: (a) the acute care general hospital; (b) the rehabilitation hospital; and (c) the extended treatment hospital (or the hospital for chronic illness).

It is understood, of course, that lines of demarcation between these T. A. J. Cunnings, Winnipeg, Man. n

types of facility are not clear and specific, and their utilization for individual patients must be decided, as always, by individual circumstances and conditions. Nevertheless, these appear to be the fundamental hospital units required. What primary services does each provide?

(a) The general hospital is basically designed, equipped and staffed to enable the physician or surgeon to treat patients requiring intensive therapy for a short period of time. Many patients, who are potentially long-term, require this type of care initially, and hence most first admissions will be to the general hospital.

(b) The rehabilitation hospital is designed, equipped and staffed to provide a program of physical and psychological rehabilitation, to restore disabled persons to the fullest mental, physical and social usefulness of which they are capable. Its purpose is to provide service to any individual who shows promise of benefitting from physical and rehabilitation medicine, and related measures, to the point where he can be restored to a reasonable normal life and environment. Its basic treatment is in the field of physical medicine, and usually the chief of staff is a specialist in this field. In addition to a specially trained nursing staff, it employs physiotherapists, occupational therapists, remedial gymnasts, re-

From an address presented at the Western Canada Institute, Vancouver, B.C., September, 1960. The author is executive director, Sanatorium Board of Manitoba.

creational therapists, speech therapists, clinical psychologists and medical social workers. There is close co-operation with agencies providing vocational assessment and counselling, and related rehabilitation measures. An ambulant patient dining-room is required. Adequate hydrotherapy facilities are necessary. There should be a large out-patient department, providing not individual occupational or physiotherapy treatments, but half or full day programs.

The rehabilitation hospital is best located in a major medical centre, adjacent to a general hospital, for the convenience of visiting physicians and consultants and use of the general hospital services (facilities for major surgery, special laboratory and x-ray procedures, et cetera) where these are required. Length of stay averages 40 to 60 days.

(c) The extended treatment hospital is designed, equipped and staffed to care for the long-term patient who will require hospitalization for an indeterminate period. Under medical direction, it provides skilled nursing service, physiotherapy, occupational therapy, hydrotherapy and diversional therapy. Its admissions will come largely from general hospitals or by transfer from the rehabilitation hospital when it appears that the patient is not likely to be rehabilitated within a reasonable time.

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Providing the Facilities

Who is to provide these facilities for the care of long-stay patients? One can hardly pick up a hospital journal from the United States these days without seeing the answer to this question: the general hospital, of course, should add another wing and get into the business! In some instances this

undoubtedly is a practical way to deal with the problem. But it is not a policy to be accepted blindly and without careful examination. Sometimes it may not be the best way.

As a rule, it should cost about 60 per cent of general hospital costs to provide care in a rehabilitation or extended treatment hospital. About 5 per cent of general hospital patients are in the over 30-days category, and about 11/4 per cent are probably suitable for active rehabilitation therapy. This is a low percentage of patients; but Saskatchewan figures indicate that this 5 per cent accounts for almost 1/3 of the treatment days in general hospitals! General hospitals are expensive to build and to operate, and there is continual pressure to build and expand. Surely, before spending large sums for new general hospital beds it would be advisable to transfer the longstay 5 per cent of patients to more suitable accommodations and use the 1/3 of present capacity which they occupy for the purpose for which it was designed, i.e., the care of the acutely ill.

It is obviously impossible to provide the rehabilitation and extended treatment services detailed above in 90 per cent of general hospitals, because they are too small to support such services. Where they are established in the large general hospitals, even if the standard of care is satisfactory, there may be a costly duplication of personnel and equipment, since each large hospital will demand its rehabilitation and chronic disease wing. I should point out that inspection of a number of rehabilitation and long-stay facilities in the United States and Canada impressed a Winnipeg Committee (of which I was a member) with the reat desirability of keeping rehabilitation units separate from extended treatment units, partly because of the psychological benefits.

Many especially successful rehabilitation and long-stay hospitals are run by authorities other than general hospitals, e.g., Dr. Howard A. Rusk's Institute of Physical Medicine and Rehabilitation in New York; the Kessler Institute for Rehabilitation in West Orange, New Jersey; The Workmen's Compensation Board Hospital and Rehabilitation Centre in Toronto, Ont.; the Municipal Hospitals in Winnipeg, Man., to mention but a few. But regardless of the administrative authority, it seems that a measure of regional centralization is desirable.

With transportation as easy as it is today, there is really no great problem about transferring patients to obtain specialized care in regional centres, within reasonable distances. It is our experience that the patient often gets a real uplift from changed surroundings. Surely visitors can reasonably expect a drive of an hour or so to see relatives, if the patient is getting the care and treatment that is needed. So far as continuity of medical care is concerned, there must be free choice of doctor, but we find that only about 1/3 of the longstay patients have a private physician, and 2/3 are looked after by the resident staff.

It is encouraging to find so much recognition today of the need for intelligent care of the patient with long-term illness and disability. The problem is one that presents a major challenge which demands the very best thought and planning by hospital authorities. The results of our present efforts and our decisions in this area will have a material effect on the care of the sick and the finances of the community now and in the future.



Course in Nursing Uni. Administration

Nurses interested in enrolling for the extension course in nursing unit administration should submit their applications not later than April 30. Applications will be accepted from nurses who are engaged in positions of assistant head nurses, head nurses or supervisors and are unable to attend a university school of nursing. Directors of nurses in small hospitals may also enrol.

The course will start with a workshop in September to be followed by a seven month period of home study. A final workshop will be held in May of next year.

This course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association. (See *Canadian Hospital*, November, 1960, p. 33).

Information and application forms may be obtained by writing to: Director, Extension Course in Nursing Unit Administration, 25 Imperial Street, Toronto 7, Ont.

Pharmacy Internship

at Women's College Hospital

THE first post-graduate program of organized training in hospital pharmacy in Ontario has been established recently at the Women's College Hospital, Toronto. This fifty-week pharmacy internship has been designed to provide supervised experience in all phases of hospital pharmacy administration and practice, and also includes planned periods of observation in other areas of the hospital, and participation in conferences and staff meetings pertaining to hospital oragnization and medical therapy.

Responsibility for the program has been assumed jointly by the hospital and the faculty of pharmacy, University of Toronto.

Weekly pharmacy staff conferences are conducted by the chief pharmacist with the guidance of the faculty advisor on the internship program, and these serve to coordinate the theory and the practice of hospital pharmacy, and endeavour to bridge the gap between academic training and actual experience.

In the first half of the program, progressive experiences are scheduled on a weekly basis and the intern is assigned to and given supervised instruction in the following specific activities: in-patient and general dispensing; out-patient dispensing; bulk compounding and preparation of sterile products; bulk compounding and prepackaging of non-sterile products; administration of pharmacy services in the hospital.

After becoming acquainted with the over-all administration and operation of the pharmacy department, these areas are revisited in the rôle of the staff pharmacist, assistant chief pharmacist, or chief pharmacist, and the time interval in each section is determined by the progress and aptitudes of the intern.

The author is chief pharmacist at the Women's College Hospital, Toronto, Ont.

Mrs. Phyllis Yagi, Toronto, Ont.

Prepared papers are presented at monthly seminars which are attended by members of the pharmacy staff, faculty of pharmacy, and interested hospital personnel.

The Hospital

The Women's College Hospital was founded in 1913. It is a fully accredited public general hospital with 279 adult beds and 103 infant bassinets, and has all branches of medicine staffed by women physicians and surgeons. The hospital is approved by the faculty of medicine, University of Toronto as a teaching hospital for medical students in obstetrics and gynaecology, medicine, and surgery, by the Canadian Medical Association for the training of junior medical interns, by the Royal College of Physicians and Surgeons of Canada for resident training in anaesthesia, bacteriology, internal medicine, obstetrics and gynaecology, general surgery, and pathology, and by the Department of Health, province of Ontario for the training of student nurses.



Sister Ruth Marie Hunter.

The pharmacy is in the new wing of the hospital which was opened in October 1956. A generous donation from the Bickell Foundation helped to provide the present facilities which were planned and developed to accommodate a pharmacy internship program.

The pharmacy is located on 2 floors of the northwest corner of the hospital. The out-patient and inpatient dispensing areas, the office, library, active storage room and a minor manufacturing room are located on the main floor. The outpatient pharmacy is directly connected to the rest of the pharmacy department and is near the outpatient waiting room. On the service floor below, are the sterile solution room, area for bulk compounding, prepackaging, and filling ward baskets, as well as the bulk storage room. A stairway connects this section with the rest of the pharmacy on the main floor. The total area of the pharmacy is 1,596 square feet.

The pharmacy staff includes four registered pharmacists, two lay helpers and one office clerk.

The pharmacy department complies with the Minimum Standard for Pharmacies in Hospitals as adopted by the Canadian Society of Hospital Pharmacists.

Relationship to the Faculty of Pharmacy

The Joint Committee on Pharmacy Internship serves as a means of communication between the hospital and the faculty of pharmacy, University of Toronto, with whose co-operation this program is conducted. The membership is as follows: hospital-administrator or her appointed representative, director of nursing, and the chief pharmacist; medical staff-representative from Medical Advisory Committee, and the chairman of the Food and Drug Committee; faculty of pharmacy-dean or his appointed representative, and the faculty advisor on internship program.

Written reports on the progress of the intern are relayed by the administrator to the committee which has assumed the responsibility for the guidance and the development for the program.

The intern, with the approval of the committee is encouraged to enroll in academic courses at the University of Toronto.

Upon the satisfactory completion of the program, the candidate is awarded a certificate by the Women's College Hospital.

(concluded on page 87)

N 1951, with pressure on avail-Table hospital bed accommodation increasing, a new aspect of home nursing care was explored and made the subject of a pilot study in the Vernon area of British Columbia. The objective was to determine if professional nursing care in the home could be provided to convalescent patients discharged after a shorter than normal period in hospital. The purpose was, of course, to free hospital beds for more acutely ill cases. The program was expected to benefit the hospital, provide a service to the community, and effect an economic saving through the earlier release of patients from hospital.

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It should be emphasized that the home nursing care program is not administered by the local hospital but by the local public health branch. However, the hospital advises the health unit of patients in the hospital suitable for home care. A home care advisory committee is in operation and includes the following people: a medical health officer - director of the program; a senior public health nurse administrator of the program; a member of the hospital board; a member of the medical staff; the hospital administrator; the superintendent of nursing; and a social worker. This committee meets on occasion to deal with any problems arising and to make changes in the regulations as necessary

Early studies in the Vernon experiment revealed that the service had proved to be of value far in excess of its cost and much less time-consuming than was first anticipated. Daily cost per patient of the service was only a fraction of the current per diem hospital cost. For instance, in 1953 the over-all per diem cost of the program per patient was \$2.06 against the hospital's \$11.35 for an all-inclusive hospital service. In 1956 the per diem cost of the program per patient was \$2.15 against the hospital's \$12.40 and the ratio is similar today, so that there is a tremendous economic saving through home

Other communities expressed interest in the project and it became obvious that there was a need in many parts of the province for an organized and continuing public health service that would both benefit the patient and offer a

From an address presented at the Western Canada Institute, Vancouver, B.C., September 1960. The author is administrator, Vernon Jubilee Hospital, Vernon, B.C.

Home Nursing Care-

a public health service

J. O. Dale Vernon, B.C.

measure of relief against the increasing pressure on hospital accommodation. It was clear also that there was a need to apply the program not only to post-hospital patients, but to the many aged and chronically sick persons whose physical and emotional conditions did not require acute hospital care.

In the following years, the program of nursing care in the home was extended. By the end of 1959 it was in effect in eight other communities in British Columbia, and early in 1960 four more communities had the program installed as part of the regular health service. Several others are being negotiated. This wide acceptance of the program and the annual increase in the volume of home care provided are a significant demonstration of its value to chronic and convalescent patients alike. home service now includes hypodermic injections, enemas, bedbaths, treatments, dressings and, on occasion, more extensive procedures, all as ordered by the physician. All are available every day of the week without cost to the patient except for drugs.

Basic requirement for inclusion of a patient in the program is referral by a private physician. It has been found advantageous to have the hospital staff nurses acquainted with the availability of the home care service. Where doctors and nurses are constantly aware of this professional care provided in their community, the demand for it increases.

With this extension of public health service, it was necessary to provide additional nursing staff. The increased cost to the local health branch was borne by an additional local assessment of 10 cents per capita.

Application of the Plan

First of all, to make the hospital home care plan known to all, extensive publicity was given the plan through the medium of the local press. Notices explaining the plan were hung in the hospital. Pamphlets were distributed to prospective patients who might be transferred to this plan. The head nurse on each floor handed pamphlets to any patient, who in her opinion, was a suitable case for the plan.

A patient is transferred only with the approval of the doctor and further instructions are then given by the doctor to the public health nurse. The nurse keeps in touch with the doctor advising him of the patient's progress. Should the patient take a turn for the worse, re-admission to hospital is prompt. Should a patient need equipment such as a bedpan, crutches, et cetera, these can be borrowed from the local branch of the Red Cross Society which maintains a "loan cupboard" of such supplies. A chart for each patient is kept as long as the patient is on the plan. It is filed at the health unit office after discharge.

On discussing home nursing care programs with federal authorities in charge of national health grants, I was advised that grants are available for those areas desiring to institute such a program. Application for these should be made through provincial health authorities. Assistance is also available, of course, from the provincial department of health.

For those interested in setting up a home nursing care, the following steps must be taken (a) enlist the co-operation of your local health agency; (b) sell the community and medical staff on the idea of home care; (c) apply for a grant and seek further financial aid from your local municipality; and (d) give the program ample publicity.

It is my opinion that home care is becoming far too important to be overlooked much longer; and I suggest that those interested in keeping up with this new concept in patient care seriously consider such a plan.



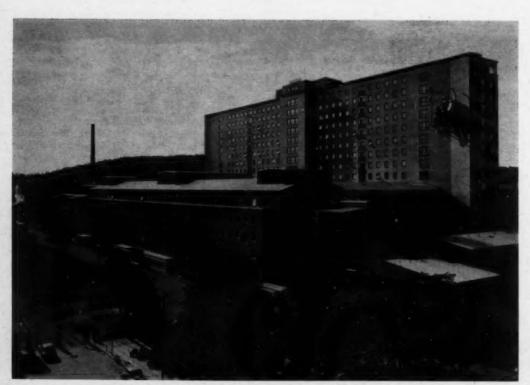
Entrance hall with information booth.

Teaching and out-patient services stressed at

SAHLGRENSKAH



Nurses' Station.



Note the large out-patients' area in the foreground.



Part of a four-bed ward.

KAHOSPITAL

Architects: G. Birch-Lindgren & E. Lohk Gothenburg, Sweden

THE Sahlgrenska Hospital in Gothenburg, Sweden, was built in 1900 as a pavilion type hospital with 400 beds. To meet the needs for additional clinics and service units, a number of detached buildings were erected on the hospital site over the period 1930 to 1944.

An architectural competition was arranged in 1944 to find a solution for the further enlargement and modernizing of the hospital. As a result of this competition, a new block in the very center of the hospital was decided upon, to replace five of the old pavilions.

As a first step in the realization of this program two wings of the new central block containing ward units were built. The patients from the old pavilions were moved to these wings and the old ones were demolished. At the same time a new kitchen and dining room unit were erected.

The construction of the central block was started in 1952. The now completed block, covering an area of 117,326 square feet, is one of the largest hospital units in Sweden. The block has a volume of 9,531,250 cubic feet and the cost has amounted to \$16,928,000 (92 million Swedish crowns) and the cost of equipment was \$3,128,000 (17 million Swedish crowns).

The central block contains complete clinics for general surgery, neurosurgery, orthopaedics, general medicine and neurology, each with ward units, outpatient departments, surgery and laboratory departments, and facilities for research and teaching.

The central block also accommodates departments serving the whole hospital, such as central sterilizing, physical therapy and x-ray diagnostic departments. The latter are the largest and newest in the country with a complete line of modern apparatus installed at a cost of about \$1,472,000 (8 million Swedish crowns). There are facilities for 120 to 140,000 examinations a year.



Operating theatre.



Day-room.

Of the total number of beds in the hospital, figured to be over 2,200 the new block has 850. A completely automatic pneumatic tube system is installed connecting every department. At the hospital an extension of the central block is already under consideration.

Sweden is divided into 31 medical areas and the Sahlgrenska hospital serves as one of the country's five regional hospitals, equipped for special care of patients, research and medical education. A new medical school has recently been inaugurated on a site adjoining the hospital. The state defrays the full cost of medical education at university hospitals, and pays for the care of the mentally ill, the crippled, and those suffering from tuberculosis.

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PUBLIC relations has been defined, in the words of one wit, as "the art of treating the public better than your relations." But no matter what definition you choose to tag it with, a good public relations program is of vital importance if hospitals are to solve the problems they face today. There are three major problem areas that need immediate attention.

Funds

A newspaper clipping dated October 3, 1960, states in part, "Ontario will have to find an additional 1500 new active treatment hospital beds every year to cope with the continuing increase in population. With hospital construction costs ranging anywhere from \$15,000 to \$17,000 a bed, this represents an annual capital expenditure of about 15 to 22 million dollars, two-thirds of which must be provided at the community level. since combined federal and provincial grants for new hospital construction offset only about one-third of the total cost."

It is quite apparent that this particular problem is not as severe in some provinces as it is in others. But the fact remains that whether 20, 40 or 60 per cent of our capital funds must be raised by the community - community support is vital to ultimate success. What's more, it seems evident that neither the provincial nor federal levels of government are prepared, immediately, to take a deeper dive into this area of capital financing. Hence, the onus for providing the balance of funds rests entirely with the community. That is our first problem.

Does the Public Understand?

Another clipping, dated September 29, 1960, quoted an elected official to a municipal council, saying in part: "Hospitals are crammed to the doors and should not be losing money, yet every time they want an addition they gouge into the public's pocket. I don't know of any more flourishing business than hospitals today. They are getting good rates and they have a reserve fund that they allow to grow larger and larger while they delve into the taxpayer's money. It is high time there was legislation so that if people charter themselves into a charitable organization their reserves could be turned over to the government to be dispersed for other uses."

That is the hospital business as

The author is director of public relations, Ontario Hospital Association.

Perk up your PR

Program

G. Stuart Roberts,

Toronto, Ont. seen by one of our elected officials! If ever there was a blatant case of misinformation and misunderstanding, this was it. Exaggerated, to be sure, but if an elected official has such a weird interpretation of how hospitals function, it makes one wonder what the public (who have no opportunity to get inside the hospitals to see the situation for themselves) must think. Why does hospital care cost so much? Hospital management knows why. But does the man in the street know? On the whole, the answer to that question is negative. And it is because of this lack of understanding that hospitals are prone to be criticized. This, then, is our second problem - getting the hospital's cost story across to the general public in terms they can completely understand.

Why Staff Shortages?

A glance at fifty survey reports received by the Canadian Hospital Association for 1959 indicates that in order to round out their full complement of staff, these hospitals require at least 600 registered nurses, 200 other nursing personnel, 154 technicians and many others. Never before in hospital history has the problem of adequate staffing been so acute. It is no secret that some large hospital extensions which were opened within the past 12 months are not yet fully operative due to the lack of sufficient staff. Why this shortage? Part of the reason lies in the fact that a number of our prospective nurses, technicians, and others are literally being stolen from us. Ironically enough, one of our most effective rivals is the teaching profession. Only a few years ago, there was a serious staff shortage in both public and high schools. But by various means, teaching was made to seem glamorous and students flocked to teachers' colleges; and in less time than it took for a student nurse to learn the difference between a hypodermic and a hypochondriac, those other young hopefuls were fully fledged career people. Now they do so well that, in Ontario, the emergency teacher plan has been suspended, while hospitals still have staff vacancies and their new extensions stand idle. It is apparent that something must be done, if hospitals ever hope to hold their own in the battle for the talents of our youth. Thus we have facing us the three penetrating problems which must be solved. First, the need for unqualified community support in the area of hospital financing; second, a clearer understanding of the "why's" of hospital costs; and three, to find a means to encourage more young people to select any one of the many career opportunities available to them in hospital

Understanding

How do we solve them? To begin with, it is imperative that we face reality and admit that all the problems we have just outlined are in fact as serious and as complex as ses, ally ally tive ion. was ooth by ade ents and a fer-all and error in the residual to the r ttle ne-be unthe nd, the nge ny in-tal gin ace ob-in as AL



has been suggested and that they won't be dissipated by ignoring them. An early step should be the launching of a vigorous program under the slogan "Operation Understanding"; and this should begin at home i.e., the hospital. In other words, hospital authorities should start educating the staff. They need not be concerned about senior personnel at the administrative levels, but in all other levels of staff there is apparently very fertile ground on which to sow the seeds of understanding.

Some time ago the writer went into a number of hospitals with a tape recorder and questioned hospital people at random on several aspects of the hospital business. The group questioned included laboratory technologists, certified nursing assistants, registered nurses, office staff, engineers, x-ray technicians, physiotherapists and others. It is significant to note that the majority of these were people who came in direct contact with the patient.

The questions asked included the following: Do you, as a hospital employee, feel that hospital costs are excessive? Why do you think hospital care costs so much? Have you any idea of the cost of hospital construction? Is the rate charged for care in hospital the actual cost or does some of the money charged go into a fund which will help finance new construction? Who owns the hospital? One would reasonably expect that anyone who works in a hospital should have at least partial answers to these questions. However, during the course of the study, it was immediately apparent that the majority of people did not have the answers.

For example, on the question of ownership, replies ranged from "the board of directors", "the medical staff", "the government" to just plain "I don't know"! Subsequently, the taped answers were played before a group of administrators and they created such an impact that one of the administrators promptly carried out his own survey. His findings not only confirmed what the writer had found, but he was most chagrined to discover that a good number of people on his staff didn't even know who the administrator was.

Five immediate conclusions were drawn following the surveys. They were: (a) the majority of hospital employees do not feel that hospital costs are excessive; (b) they do not have sufficient facts at their disposal to explain why they are so high; (c) very few have any idea of the actual cost per bed for hospital construction; (d) the majority do not know where the funds for this purpose come from; and (e) a great number are convinced that since the inception of government-sponsored hospital insurance, governments own and operate the hospital.

All this poses an interesting question: if people on staff in our hospitals have such a mixed up interpretation of hospital facts, is it any wonder that the average citizen is more than a little confused?

Staff

It is imperative that the hospital administrator get to his staff, either directly or through his department heads, to acquaint them with the problems facing hospitals, and explain to them how they can do more than any other group of individuals to overcome these problems. Hospital employees should be given every possible bit of information that will help them to interpret this complex story. Tell them who owns the hospital; why it costs so much for a day of care; how much it costs to put up an extension; explain the limits of government assistance; where funds come from for new equipment; tell them this and more. There is no limit to the good than can come from thousands of hospital employees interpreting the true hospital story to those people with whom they come in contact.

Media

Every use should be made of boards, staff papers, bulletin bulletins mailed to the employee's home, et cetera. This method of communicating the printed word may not bring the desired results, as it is questionable just how much a person will read or can read. In the opinion of the writer, the best possible method for getting this story across is through weekly sessions with the department heads and subsequently the department heads with their staff. Fifteen minutes at a time over a period of a few weeks should be sufficient. Many people are convinced that there is no substitute for the wordof-mouth method of communication.

This is truly public relations working from the inside out. Public relations cannot succeed without the complete support and understanding of the people within the organization. It is much too easy to fall into the rut of placing a person on the job, assigning specific

duties, and letting the employee carry his own (and possibly somewhat distorted) view of the organization's operations to the outside world. There are undoubtedly a number who will shrug off any question with the "Oh, I don't know; I just work there" type of reply, but surely these are in the minority, and it is the responsibility of management everywhere to furnish the willing majority with all the information they require.

P. R. Committee

Once the initial objective has been accomplished and management are confident that they have a solid corps of dedicated salesmen working for them both on and off the job, subsequent efforts should be directed to the education of the general public. The goal here is simple: to turn the tide of public opinion, so that it is chasing hospital critics instead of hospital executives. This can be achieved by setting up a strong, active and energetic public relations committee, consisting of key members of the hospital board, along with a few non-board members who are not necessarily thoroughly conversant with hospital problems but are skilled in the art of communication. These may be newspaper editors, reporters, advertising executives, and radio station personnel. It might be wise to suggest that prospective committee members might be more eager to co-operate if approached by board members who, themselves, devote their time and talent to the hospitals, rather than by the administrative staff. If they are sold on the idea that their help is important, these people could be of tremendous assistance.

For the Masses

Once the public relations committee is formed and ready for action, plans should be started for a long-range program for the masses. There are many publics which one can't afford to overlook. And this includes members of city and town councils, executives, and members of such civic groups as the local chamber of commerce, service clubs, church groups, parent-teacher associations, union groups, et cetera. Once contact with these groups has been made, hospitals would be well advised to have a speakers' bureau formed - consisting of prominent board members or key hospital people who are completely familiar not only with the local picture but with the entire provincial hospital story. Thus when any of the mentioned groups request a speaker on

recent advances in sterilization

Ethylene Oxide

Peter Warner, M.D., Ph.D. Winnipeg, Man.

THE first article in (see Canadian Hospital, January, p. 33) was concerned with the new high-vacuum autoclave equipment that in reality is an improvement of existing apparatus. Nevertheless, it is an improvement providing startling results. This article describes what is really a new principle: the sterilization of materials used in medicine by permeation with gas. It is true that in the past other gases have been used in attempts to sterilize, for example, chlorine, sulphur dioxide and formaldehyde; however of these only the last has been used at all extensively, but it has been shown to be unsatisfactory since the gas has no power of permeating and merely condenses on easily accessible surfaces. Also, formaldehyde requires a high humidity to be effective (an undesirable feature for goods that are required to be dry) and the necessity for this suggests that formaldehyde does not act as a gas but as formalin-a loose compound of the gas and water. On the other hand, ethylene oxide, the gas we are going to consider, has the property of permeating many materials including plastics and rubber, and its sterilizing activity is favoured by high humidity, thus it is thought to be active as a gas. It becomes clear that the principle of the use of ethylene oxide is different from that of formaldehyde.

Where it is not specified, the information that follows was obtained from Phillips and Kaye (1949),

Kaye (1950), Phillips (1958), and Thomas (1960).

Ethylene oxide was first described in 1859, but it was not until 1928 that it was used to kill a wide range of insect pests. In the following years it became an industrial fumigant particularly in the food trade, Its anti-bacterial properties were described in 1929 but bacteriologists in general were unaware of its existence until the subject was reviewed by Phillips and Kaye (1949).

These men in Fort Detrick, Md., were looking for a suitable gaseous sterilizing agent. First of all, they used up the only available small bottle containing 50 grams of ethylene oxide and, then, during the time it took to re-order more, they discovered that this material had been widely used and there were some 200 papers on its use as an insecticidal fumigant. Much of the previous published work on ethylene oxide was hidden in the patent literature. Subsequently, they discovered that a major spice importer in Baltimore, only 45 miles away from Fort Detrick, was using ethylene oxide to sterilize spices. Furthermore, they discovered that another bacteriologist at Fort Detrick, engaged on a completely unrelated project, had done some work in the past in which he had shown that soil could be sterilized with ethylene oxide.

It was a series of four papers by Kaye and Phillips that caused the bactericidal properties of ethylene oxide to be widely known and recognized. At about the same time, in the Journal of the American Medical Association a paper appeared by Wilson (1950) of du Pont describing the use of ethylene oxide in the sterilization of plaster bandages. In the last ten years ethylene oxide has been

used more and more widely for the industrial sterilization of surgical and medical goods including plastics and other things damaged by heat including drugs. More recently it is becoming evident that it has useful applications in medical research and hospital practice. Ethylene oxide is readily available since it is widely used as an alkylating agent in the chemical industry for the preparation of acids, esters, ethers, surfaceactive agents and detergents.

Properties

Ethylene oxide at room temperatures is a freely diffusible gas able to penetrate paper, cellophane, fabrics and many (but not all) plastics. On cooling to below 10 degrees Centigrade the gas condenses to a colourless liquid. Ethylene oxide is freely soluble in water, oils, nearly all organic solvents, rubber, neoprene and some plastics.

Liquid ethylene oxide is stable to detonating agents but the gas is explosive. The gas, however, can be made safe by dilution with carbon dioxide or fluorocarbon gases known as "freons".

Toxicity

(1) By inhalation-Owing to its wide use in industry the toxic properties of ethylene oxide have been well studied. Animal experiments show that, on inhalation, ethylene oxide is about as toxic as ammonia. A suggested suitable industrial standard upper limit is 50 parts per million (p.p.m.) although there appears to be general acceptance that 1000 p.p.m. or less is not toxic. The first symptoms caused by exposure to the vapour are usually irritation of the eyes and nasal passages—this has been found to occur in man at a level of 2,500 p.p.m., whereas 12,500 p.p.m. caused definite irritation to the nasal passages in 10 seconds. The next symptoms are nausea, vomiting and headache. These are usually the only symptoms and they rapidly clear up. However, there have been rare instances of more serious illness and death as a result of industrial accidents in which ethylene oxide has been liberated. As the vapour will diffuse through certain plastics it is simple to devise plastic containers holding indicator systems which will change colour when exposed to various concentrations of ethylene oxide.

(2) Vesicant Action — Solutions of ethylene oxide have a vesicant action on the skin and may cause conjunctivities if splashed in the eye.

The author is director, department of bacteriology, Winnipeg General Hospital and associate professor, department of bacteriology and immunology, Medical College, University of Manitoba, Winnipeg.

Workers who had been drenched from the waist down with a 1% solution of ethylene oxide developed very large blisters after a latent period of six or more hours. In experiments with human volunteers it was found that on freely exposed skin surfaces pure liquid ethylene oxide boiled rapidly and caused no injury other than temporary freezing. If solutions of ethylene oxide were kept in intimate contact with the skin, varying degrees of vesication occurred after a latent period. In accidental burns an important factor in determining the extent and distribution of blistering is whether the solution of ethylene oxide has been held in contact with the skin by gloves, shoes, clothing, belts, watch straps or jewellery. Skin lesions due to ethylene oxide have been reported when people have come into contact with freshly sterilized articles such as boots, shoes and gloves. Although ethylene oxide normally evaporates very rapidly, some substances, such as rubber, absorb large quantities and it may take some time for the ethylene oxide to disperse.

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(3) Hypersensitivity Reactions— It has also been shown that with repeated exposure ethylene oxide will produce sensitization.

Anti-bacterial Activity

A wide variety of organisms have been exposed to ethylene oxide in one form or another. The gas is bactericidal and will also destroy spores at a concentration not very much greater than is required for the corresponding vegetative organisms. With most chemical disinfectants, bacterial spores are many times, often thousands of times, more resistant than vegetative cells. With ethylene oxide, spores are usually only slightly more difficult to kill than vegetative cells and several workers have noted survival of organisms such as staphylococcus aureus when heat-resistant spores have been killed (Eisman, 1951; Thomas. West, and Besser, 1959). The gas is active against tubercle bacilli and the viruses it has been tested against. Ethylene oxide has also sterilized laboratory media, heavily contaminated throat washings, feces, floor sweepings and soil.

Ethylene oxide is believed to act as an alkylating agent because it has considerable chemical activity and is capable of reacting with many substances of biological importance including amino acids, proteins, and nucleoproteins, (Phillips, 1949; Alexander, 1954). There are a number of related substances, some of which are bactericidal, but for one reason or another ethylene oxide is the preferred one.

Factors Affecting Sterilization

The main factors affecting the sterilizing action of ethylene oxide gas are:

(1) Concentration of Ethylene Oxide — At present concentrations of 10 to 20 per cent are used; the frequently quoted percentages refer to the specific condition of initial vacuum, temperature and pressure of presently available equipment—more accurately stated, the concentration of ethylene oxide is between 360 and 1000 milligrams per litre (Shull, 1960). The higher the concentration the greater is the sterilizing action. However, above 20 per cent the risk of flammability is apparently high.

(2) Temperature—As far as has been tested the higher the temperature the greater is the sterilizing action of ethylene oxide. Too much heat of course would defeat one of the purposes of ethylene oxide sterilization, that is, its ability to sterilize things that are destroyed by heat. At present one type of apparatus uses a temperature of 130°F. (54°C.) during sterilization with ethylene oxide.

(3) Humidity — Ethylene oxide sterilizes less efficiently when humidity is high than when it is lower. On the other hand, complete dryness affects adversely sterilization by ethylene oxide. Ethylene oxide (10 to 20 per cent) is most efficient at relative humidities of 30 to 60 per cent when used at 130°F. (54°C.).

(4) Time—As with every other disinfecting or sterilizing agent, materials must be exposed to ethylene oxide for a sufficient length of time. Using ethylene oxide under the conditions of temperature, humidity and concentration mentioned in the last paragraph, up to 3 or 4 hours may be required for sterilization (Skeehan, King and Kaye, 1956), although others (Davis et al, 1957; Skeehan, 1959) claim that certain things could be sterilized in one hour. It is suggested that higher temperatures would shorten sterilizing time (Thomas, 1956).

Articles Sterilized

The main advantage of ethylene oxide as a sterilizing agent is that it can be used to sterilize objects which cannot ordinarily be sterilized by other means. Sterilization can be carried out at low temper-

atures. The gas rapidly diffuses through closed containers of paper, fabric and plastics. It is soluble in oil and water. It is active in the presence of organic matter. It is relatively non-toxic and causes little damage to a wide range of materials and at the completion of the sterilization process the active agent rapidly diffuses away.

Ethylene oxide has been used to sterilize a wide variety of things such as rockets destined for outer space, a whole army truck, the inside of an aeroplane contaminated with poliovirus, tobacco, cosmetics and many foodstuffs including fruit juices, vegetable oils, spices, flour, sugar, starch, bread, and eggs with intact shells.

In the medical field ethyelene oxide has now been used widely for the following things:

- (1) Bacteriological media.
- (2) Drugs, such as antibiotics of which some lose potency during exposure to ethylene oxide.
- (3) Plastics—a very wide variety of plastics are sterilized by ethylene oxide because they are sensitive to heat. Many, if not all, disposable plastic items used in hospital and by doctors are sterilized by ethylene oxide.
- (4) Domestic Articles many such articles require decontamination after exposure to infections including gastro-enteritis, staphylococcal sepsis, and tuberculosis. These include all types of clothing (wool, cotton, silk, rayon, nylon, fur coats), footwear, books, radios, and so on.
- (5) Bedclothes these may require decontamination at home or in hospital. Ethylene oxide sterilization is particularly useful for blankets, pillows and mattresses for which there is, for all practical purposes, no other convenient method of sterilization.
 - (6) Hospital Equipment:
- (a) dressings and sutures many commercial firms sterilize their dressings and sutures with ethylene oxide for use in hospitals.
- (b) rubber—it is claimed that it is perfectly possible to sterilize and maintain the softness of rubber gloves, catheters, and so on (Laskowski, 1960). It is also claimed that they last longer.
- (c) lenses and other glass containing instruments ophthalmoscopes, cystoscopes, and bronchoscopes have been satisfactorily sterilized with ethylene oxide.
 - (d) sharp instruments.
 - (e) complex apparatus and mis-(continued on page 70)

Les Relations Publiques Personnel Hospitalier

DEPUIS quelques années nous sommes à même de constater combien d'une part la population en général s'intéresse pour ne pas dire se préoccupe des problèmes hospitaliers et combien d'autre part les hôpitaux attachent une importance plus grande à se faire connaître du public. Dans une telle conjoncture, il est capital pour le personnel hospitalier de comprendre en premier lieu ce qu'il faut entendre par les relations publiques et en second lieu pourquoi l'institution qui l'emploie compte sur lui pour amménager de saines relations publiques.

La nature des relations publiques

Les relations publiques à l'échelon d'une entreprise peuvent être définies comme le secteur de la direction dont l'objet est de faire naître ou développer la confiance et la compréhension du public envers l'entreprise et de l'entreprise envers le public. Cette fonction est considérée de plus en plus comme enpartie distincte de l'administration générale, mais néanmoins intégrée à cette dernière.1

La plupart des grandes institutions des toutes les branches de notre vie économique, politique et sociale reconnaissent qu'elles doivent maintenir des relations harmonieuses avec la collectivité qu'elles servent et avec la population en général. Toute entreprise qu'elle soit de căractère privé ou public, à but lucratif ou non lucratif, doit prendre en considération qu'en poursuivant son objectif propre, elle entre nécessairement en con-

Louis-Philippe Brizard Montréal, P.Q.

tact avec le public qui utilise le produit qu'elle met sur le marché ou le service qu'elle rend. Elle ne doit pas ignorer non plus le fait qu'elle est solidaire ou associer qu'elle le veuille ou non à la région dans laquelle elle se développe. Des rapports s'établiront donc bons ou mauvais entre elle-même, son public particulier et celui de sa région. Les relations publiques bien organisées auront la responsabilité de faire en sorte que ces rapports du public et de l'entreprise se voient donner l'importance qu'ils méritent auprès des conseils et chefs-d'administration.

Les responsables en relations publiques

La responsabilité d'établir dans une entreprise les principes et politiques de base en relations publiques échoit à la haute direction. Dans certaines entreprises, on crée même un service spécialisé de relations publiques dont le responsable relève de cette haute direction. En d'autres termes, la direction reconnaît alors qu'une véritable solution aux problèmes de relations publiques ne sera possible que si un chef en fait sa préoccupation unique et que si son autorité et ses fonctions s'étendent à tout ce qui touche aux relations publiques. Une tendance analogue d'ailleurs avait été observé au moment de la création des services de direction ou relations du personnel.

Mais aussi bien organisé soit-il, le service des relations publiques reste quand même, comme son nom l'indique, un "service". Son titulaire n'a pas d'autorité directe sur les chefs des autres unités administratives de l'organisation ou

sur les travailleurs mêmes. Il ne possède qu'une autorité indirecte ou celle d'aviser le conseil ou chef d'administration ou encore d'établir pour celui-ci des politiques générales ou moyens que doit utiliser l'entreprise pour atteindre l'objectif qu'elle se fixe dans le domaine des relations publiques.

Quelle est la nature de cet objec-

tif? Comme principe ou philosophie de l'action, les relations publiques ont un double objectif. Elles com-

prennent d'abord une politique systématique d'information du public sur le rôle, le fonctionnement et les activités de l'entreprise. Cette politique première aura pour complément indispensable la prise en considération par l'entreprise désirs et besoins du public.º Sans déterminer plus concrètement et dans le détail le champ d'application et les techniques d'action du spécialiste des relations publiques, ce qui déborderait le cadre de la présente étude, qu'il me suffise de souligner ici, que même avec un département de relations publiques bien établi, tous les autres chefs de division, tous les surveillants et même chaque employé doit se considérer comme responsable, jusqu'à un certain degré selon la nature de son travail, de l'application des principes ou politiques de relations publiques élaborées dans l'organisation.

Le personnel hospitalier, agent de relations publiques

En un mot, tout employé d'une entreprise est un agent de relations publiques, il est un associé dans cette tâche commune de maintenir ces relations à un haut niveau d'efficacité. Pourquoi peut-on dire qu'il en est ainsi. Tout simplement parce que l'élément fondamental sur lequel une entreprise doit faire (conclu à la page 58)

Pour notes bibliographiques voir page 56.

L'auteur est professeur agrégé de l'administration du personnel à la faculté des sciences sociales et à l'Institut d'Administration Hôspitalière, Université de Montréal.

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Restorative Surgery in Rehabilitation

H. Hoyle Campbell, M.D. Toronto, Ont.

PLASTIC surgery is an ancient art. It is concerned with the reconstruction and moulding of any of the body tissues to correct its paralyzed, deformed, or disfigured part—the result of birth or growth abnormality, injury or disease. The prime purpose is to restore function with the ultimate aim of gaining a satisfactory appearance.

The techniques used include the transplantation from one part of the body to another of sheets of skin representing a partial thickness from the donor site, to be placed over a skin defect which does not require the further addition of subcutaneous fat to give a satisfactory result. This is known as free skin grafting. At times, the whole thickness of the skin is removed from the donor site for replacement in areas where more substantial skin replacement is required. For example, about the face, the skin from behind the ear is used to replace defects as the color match here is excellent. The skin of the body is a little more vellowish-white than that of the skin of the face. The disadvantage is that the donor site must be repaired, whereas in split skin graft-

ously.
On occasions, skin and fat are required and this is transported either from near the defect, or from a distance, through an intermediary pedicle on the wrist. Occasionally, the defect can be proximated to the donor site as in legs or arms. The legs can be crossed to the thigh to receive the flap, or an arm can be brought next to the body, to have its defect covered.

ing, the donor site heals spontane-

This requires that sufficient tissue be added at the time so that any further deep reconstruction can be carried out beneath. Modern plastic surgeons use new improved methods to restore bone defects and transplant tendons, muscles, nerves and other body tissues as well as skin to achieve their goal.

Where the deformity is mainly of the bony skeleton, for example, the nose, its skin can be elevated and the bone beneath reshaped. As well, its cartilage structures can be reshaped to give a more pleasing and normal appearance to the face. Improved methods have been developed for the management of scarring, skin blemishes, irregularities and wrinkling of the skin to improve appearance as well.

In some cases the defect may be too large for surgical correction and must be covered with a lifelike artificial replacement. The use of improved modern materials for this purpose has allowed many injured and disfigured persons to take their place in society.

You will see the difficulty, sometimes encountered, in classifying certain of the cases for record purposes. The original diagnosis or disease producing the deformity or disfigurement is easy enough but coding the anatomical defect and the operative repair add considerably to your problem. We have felt that many of these can best be recorded through the area involved and the deformity produced by classifying the operative repair from the general heading of the technique specifically used.

I do not like to leave this subject without mentioning the economic aspects of such operations. You will note that multiple stages have been necessary in many of the instances and it becomes necessary to foreshorten the hospital stay as much as possible to

keep down the cost. Some of these cases require all the facilities offered by the large general hospital. Many require the specific application of specialized operative techniques but, with proper postoperative fixation, the patient can be sent on his way within the 24 hour period. At the Institute of Traumatic, Plastic and Restorative Surgery, the short term cases are looked after and the more complicated prolonged cases are looked after in St. Michael's Hospital.

I could discuss at some length the details required for short term management of the postoperative patients, but will merely say here that the general anaesthetic must be so administered that the patient is not given excessive preoperative medication and that short acting anaesthetic agents should be used. Great attention must be paid to the postoperative dressing fixation of the operative site. This then puts the local area at rest completely and we can then quite safely mobilize the patient. We have applied these techniques now in over 2,000 patients and our complication rates from surgery have been the lowest I have ever had. These include hand, arm, leg, face and neck problems.

As modern medicine and surgery have advanced so greatly in the past century toward the saving of life, in many instances the problem is arising of what to do with the lives so saved. Plastic and restorative surgery, with the application of some or all modern techniques, can do much to ease the mental anguish of disfigurement and to restore function in certain of these unfortunate people.

Section on Community Psychiatry

The department of psychiatry at the Jewish General Hospital in Montreal, P.Q., is setting up a new section devoted to community psychiatry to be called the Mona Bronfman-Scheckman Section on Community Psychiatry. The new section will enable the hospital to offer, in a more efficient manner, its psychiatric facilities to community agencies. It is also expected that a clinical fellow senior post-graduate student from McGill's Diploma Course in Psychiatry - will be added to the staff of the section. Support for the new project comes largely from a generous grant by the Mona Bronfman-Scheckman Foundation.

The author is director at the Institute of Traumatic, Plastic and Restorative Surgery, Toronto, Ont. This address was presented at the annual meeting of the medical record librarians in Toronto, October, 1960.



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PROFESSIONAL DIETITIAN

prepared by the quebec dietetic association

Part II*

THE demand for hospital services has increased in direct relation to the population, which has increased by 29.4 per cent between 1948 and 1957. In addition, the use of hospitals has increased. In 1947, 71 per cent of births took place in our hospitals, while in 1958 this figure climbed to 88.4 per cent. In 1947, 46 per cent of deaths occurred in hospitals by 1956 this has been increased to 55.6 per cent.

Consequently hospitals have increased in bed capacity and larger hospitals have been built. Large hospitals are more complex to administer and require experienced dietitians. The most serious shortage is that of senior personnel who can give leadership as departmental directors. This shortage is further aggravated by the following factors:

(a) Lack of recognition for the responsibilities involved, as shown by the inadequate remuneration offered for top-level positions. As a result, dietitians who have acquired sufficient experience leave hospital dietetics and enter industry where they often reach positions at managerial level with more status and higher salaries.

The serious over-all shortage of dietitians has caused concern among hospital administrators; but in nearly all cases this concern has been directed towards improving salaries for dietitians entering the profession. The importance of strengthening the position of the more experienced dietitians, who are essential to the organization and management of the department, is usually overlooked. Although the association is very much aware of the need for increasing salaries for recent graduates, nevertheless it does not feel that

all the emphasis should be placed on improving salaries for junior positions.

(b) The relatively small salary spread between junior and senior positions. A recent survey conducted by the association showed that the salary spread is astonishingly small; there is not enough differential between the salary paid to a young dietitian without experience and a director with 10 to 20 years of experience in hospital dietetics. There was very little recognition in terms of salary for the faithful service contributed by the senior dietitian in a position of heavy responsibility. For example, in one known case, a director of a dietary department in a large hospital, who has many years of experience and administers a budget of more than \$1,000,000 receives only \$1,990 more than a beginning dietitian who has no experience, and only \$1,290 more than a junior dietitian on her staff who has very limited responsibilities.

On the other hand, in industry, the salaries for top-level dietitians are often regulated by management policy in keeping with the extent of the responsibilities involved and the number of personnel in the department. In hospitals no such policy appears to exist for administrative positions and the salary is a matter for discussion between the administrator and the dietitian. The latter, if true to professional ethics, hesitates to make demands in the face of the adminis-

trator's frequent reminders of the inadequacies of the hospital's finances. Experience has proved that low salaries for senior dietitians almost inevitably result when there is a lack of policy concerning salaries for administrative positions.

Between the senior and junior positions there are a number of positions, depending on the complexity of the department; and it is wise administrative policy not to have the salaries paid in each category overlapping, as is now the case in many hospitals. Possibilities for promotion into a higher category with a substantial increase, as well as annual increments, have proved to be worthwhile incentives in many organizations. They ensure continuity in staff and prevent the loss of potential seniors to other institutions.

(c) The necessity of working on holidays and week-ends which restricts the social activities of hospital dietitians. Their isolation is reinforced when living-in accommodation is provided.

In the past, the provision of living-in accommodation on the hospital premises was considered by many administrators as justification for a lower salary. This practice is not recommeded. It is felt that a senior dietitian should live in the community and be recognized as a professional person, so that she may have an objective view-point in her relations with the public and other hospital departments. In a well-organized dietary department there is no need for the senior dietitian to live in.

In fact, senior dietitians and as many junior dietitians as possible should be encouraged to live away from the hospital, since for anyone in a position of responsibility it is sound mental hygiene practice to live apart from the institution.

(continued on page 84)

Food Service

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^{*}See page 45, January issue.



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Dechees Potatoes, so easy to make with Krait instants, give this siste a festive touch, as do country gravy over breaded veal cuttet and certoia glazed with Casine dressing.

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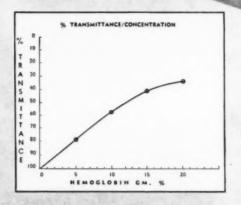
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Les Relations Publiques (conclu de la page 50)

reposer sa politique de relations publiques est une recherche constante d'accomplir d'abord et avant tout son rôle propre de la manière la plus adéquate possible. C'est à ce prix seulement qu'elle pourra gagner et maintenir la confiance

du public envers elle.

Mais l'efficacité d'une entreprise dépend pour une large part de la qualité même de son personnel. Il est donc vrai de dire que seules des bonnes relations humaines à l'intérieur de l'entreprise i.e. de relations entre le personnel et ses dirigeants et des membres du personnel entre eux peuvent servir de base à de meilleures relations entre l'entreprise et le public. On peut même parler de relations publiques intérieures pour décrire ce premier type de relations (dirigeant-personnel) et de relations publiques extérieures pour faire allusion à ce second type de relations (entreprise-public).

D'ailleurs, le premier public d'une entreprise en autant que les dirigeants sont concernés est le personnel lui-même. C'est donc dans la mesure où ce personnel s'acquitte très bien de sa tâche grâce à de bonnes politiques de direction du personnel que les relations publiques extérieures sont possibles. Aucun spécialiste de relations publiques même très avisé, je le répète ne peut atteindre ses objectifs si chaque employé, mais surtout ceux qui sont en autorité ou ont la responsibilité d'être en contact avec le public extérieur, n'accomplit son travail avec une grande compétence. Tout employé a donc en un certain sens dans ses mains, il doit en être convaincu, le contrôle d'une partie du prestige de l'organisation pour laquelle il travaille,

Au fait de ce qu'implique le concept des relations publiques d'une façon générale, j'aborde maintenant la seconde partie de cette étude en faisant ressortir l'importance des relations publiques pour l'employé d'hôpital. Deux remarques préliminaires s'imposent d'abord. L'institution hospitalière est une organisation complexe. Elle remplit deux types de fonctions: fonctions d'ordre médical et fonctions d'ordre administratif. Quand je m'en référerai maintenant à l'employé d'hôpital, j'aurai donc plus particulièrement à l'esprit cette catégorie d'employés affectés à des fonctions administratives. C'est au plan administratif que je demeurerai. Ma seconde remarque est pour indiquer que même à l'intérieur de cette dernière catégorie, je me limiterai à envisager le point de vue des employés qui ont des contacts avec le public. Cela ne veut pas dire qu'une partie de mes remarques ne pourraient pas s'appliquer à juste titre à l'ensemble des employés en général.

L'organisation structurelle de l'hôpital

Une première raison qui devrait faire comprendre à l'employé d'hôpital dont il est ici question, l'importance des relations publiques, vient de la structure même de l'organisation ou du fait que, dans l'institution hospitalière comme dans toute grande entreprise, la division du travail est très poussée. Dans la mesure où les services médicaux et administratifs sont très spécialisés, il y a cloisonnement entre les différents services et à l'intérieur des services euxmêmes. Il arrive que chaque employé travaille dans sa sphère en ignorant ce qui se produit dans les autres. Il arrive que le public qui doit entrer en contact avec l'institution ou l'habiter un certain temps est isolé, perdu et déplore le climat impersonnel qui y règne. C'est pour cette raison que l'institution hospitalière engage tout un personnel dont la fonction première et unique est celle de faciliter les communications des employés entre eux et de ceux-ci avec le public qui la fréquente.º

Or, un des objectifs de base des relations publiques nous le disions plus haut, est celui de communiquer au public ce que l'entreprise est, ce qu'elle fait, et cela d'une manière personnelle. L'employé préposé à des contacts avec le public peut être qualifié ainsi avec raison, d'agent de relations publiques. Mieux, il accomplira sa tâche,

mieux il fera connaître et interprétera les politiques de l'organisation au public. Il doit se convaincre que parce que l'entreprise a pris des dimensions énormes ses services sont essentiels.

Un système de communications ou de relations publiques n'est possible que si tous les employés en liaison avec l'extérieur comprennent eux-mêmes, dans la mesure où cela leur est nécessaire, les fonctions, responsabilités et l'autorité de chaque membre de l'organisation, département ou division de l'entreprise dont ils font partie. Le public exige que l'hôpital soit efficace non seulement dans les services médicaux qu'il rend mais aussi dans tous les services administratifs qu'il s'agisse de celui des communications ou autres. D'ailleurs, dans bien des cas, l'excellence des communications détermine l'efficacité de tous les autres services.

C'est avec les employés des services de communications que le patient, le visiteur ou le public en général établi le premier rapport et le dernier rapport qu'il a avec l'hôpital. La première impression qu'il reçoit, la dernière qu'il conserve peuvent l'influencer énormément dans le jugement qu'il portera sur l'institution.

Notes Bibliographiques

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- 2. Steinberg, C. S.: The Mass Communicators, Harper & Brothers, 1958.
- 3. American Hospital Ass. in cooperation with U.S. Dept. of Labor and U.S. Employment Office: Job Descriptions and Organizational Analysis for Hospitals and Related Health Services, 1952.

(La fin au prochain mois)

Seminar on Hospital Administration

The Sloan Institute of Hospital Administration at Cornell will offer its fourth annual Hospital Administrators Development Program to be held for four weeks from June 25 to July 21, 1961.

Supported by a grant from the Alfred P. Sloan Foundation, the program is limited to about 25

applicants.

The program is an intensive course of lectures, readings, and discussions and is divided into three seminars dealing with medical care programs, the administrative process, and trends in hospital administration.

Each seminar is under the leadership of a resident faculty member engaged in teaching and research in the subject. In addition, a visiting authority joins the seminar each day. Total cost to participants selected is \$100. This covers tuition, supplies, room, and most of the meals.

Administrators interested may obtain the brochure and application form by writing to the Hospital Administrators Development Program, Sloan Institute of Hospital Administration, Rand Hall, Cornell University, Ithaca, New York.



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Your P.R. Program

(continued from page 47)

the subject of hospitals they will never have to be turned down. In fact, hospitals should have their spies out planting the suggestion in the minds of these groups that a speaker on the subject of "Our Hospital" would be a good idea. Meanwhile, a constant barrage of general promotion should be going out to the general public. When telling the hospital story, there is no need to adopt an apologetic attitude concerning costs. Hospitals are not in the business to provide bargain basement care. People demand good quality care and are not seeking cheap substitutes. Hospital care is truly a bargain, in that the patient is assured of personal care and service, meals included, at a cost of less than \$1.00 per hour. This is a fact that must be accepted by the people and, if put in its proper light, they will have no difficulty in accepting it as a fact. This, then, should be the hospitals' solution to the first two problems, since one cannot divorce completely the story of operating costs from the story of capital costs.

Every day, without exception, there appear newspaper reports of mishaps, accidents, and sudden illness striking someone somewhere in our communities. The report will go on to describe briefly the details, and it will almost inevitably end up by stating that the person is in such and such a hospital and his condition reported as satisfactory, or otherwise. The hospital is relegated to a position of minor importance, in that it simply becomes the location where an event has occurred. Hospitals should strive to make the general public hospital conscious so that when they see such a reference, they will automatically think of a skilled team of individuals using the very latest in scientific equipment, working feverishly to effect a return to health of the individual concerned; that they will be immediately conscious of the drama which is the hospital; and the cost for the production of this drama, whatever it may be, will be well worth while. Hospitals must work for the time when the phrase "in the general hospital" will conjure up a picture -and an impressive one.

Battle for Talent

Let us move along to the battle for the talents of young Canadians. Spring has always been synonymous with courtship, and there is one courtship occurring every spring which should concern hospital

people very deeply. Immediately before graduation, each new crop of high school students is being wooed - as business and industry seek to entice bright young Canadians into their respective folds. Hospitals must launch their own courtship - underlining the opportunities and the personal satisfaction that comes from selecting any one of the opportunities available to these young people in hospital work. In doing so, they should never lose sight of the factor which, today more than ever before, may be decisive in helping these students make up their minds.

Hospital salaries have improved in recent years. Still, when one compares the salaries of nurses and dietitians with the salaries of school teachers, secretaries, and so forth, one cannot help but think that hospitals still have a long way to go. By overlooking this, hospitals would be overlooking one of the basic rules of public relations—the product must be palatable if it is to win a following. It must be appetizing if it is to hold its market. To be palatable and appetizing the career opportunities hospitals offer must not only have the intangible attraction of personal satisfaction, but the tangible ones of fringe benefits and salaries equal to those of others of similar status in the community.

Career Promotion

Some time ago the writer had the opportunity of discussing career opportunities with vocational guidance teachers in some of the high schools in Metropolitan Toronto. He was given the privilege of going through records which are kept on every student. One of the most disheartening facts gleaned from these records was that a number of students who, in grade nine and ten had indicated an interest in such fields as nursing, occupational and physiotherapy, et cetera, changed their objective by the time they reached grade 12 and 13, and eventually entered some other field, such as teaching. On the surface it would seem that someone is doing a much better public relations job for the teachers than we are doing for hospitals. True or not, this obviously points up the first requisite to a career promotion program. As always, the seeds have to be planted early-hospitals must approach the students when they are young. But more important, they must cultivate these seeds throughout the students' entire high school education. In short, keep them sold.

The Ontario Hospital Association

is now commencing to lay the ground work for an organization which they hope to form in the near future under the name of "Health Care Team of Tomorrow (H.C.T.T.). The main purpose will be to provide students from ages 13 to 17 with the opportunity to join a club that will introduce them to the various careers and professions in hospitals. It is hoped that branches of this organization will be formed in every area which has a teaching hospital. Tentative plans are that each branch would hold meetings either bimonthly or monthly. Initially, the meetings would consist of group discussions, film nights, and so forth, which would give the members some idea of what the hospital has to offer. Eventually, the members would be introduced to actual hospital work following an orientation period during which representatives of various hospital groups would have had an opportunity to discuss their work. Later, club members would fall under the category of junior volunteer workers. They would assist with actual hospital duties which might include anything from reading to blind patients to assisting in the distribution of food trays. As time progresses and the individual members of the club find themselves setting their sights on a specific career, arrangements would then be made for the member to spend his or her voluntary hospital time in a specific field.

While this may appear, on the surface, to be an organization similar to that of future nurse clubs, this is not what is intended. Hospitals need not only nurses, but also medical record librarians, xray technicians, laboratory technologists, dietitians, and many other qualified people. Hence, the stress would not be on a specific career initially, but a means whereby young people are encouraged to consider becoming a member of the health care team of tomorrow.

The formation of such clubs all across Canada would undoubtedly be of considerable help. But more specifically, hospitals must continue to provide the schools with upto-date information on hospital careers. Posters, career booklets, and other pamphlets, must be used to the fullest possible extent. Stories and articles in high school papers can prove of tremendous value; and student tours of hospitals will always be of vital importance.

It is important to remember, (concluded on page 62)

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Your P.R. Program (concluded from page 60)

too, that there are other ways to reach the students. They may be reached through Girl Guide, C.G. I.T. and Boy Scout groups. And they can be reached, too, through the parents, via home and school associations.

In short, no opportunity of getting the hospital career story across should be overlooked. As present facilities are expanded to meet the increased demand for hospital care, more and more people will be required to staff these facilities. This makes a stepped-up effort in the

field of recruitment imperative. For hospital care will always remain primarily a service by the people for the people.

International Equipment Exhibition

The third International Hospital Equipment and Medical Services Exhibition will be held from May 15 to 20 at the Grand Hall, Olympia, London, England. The exhibition is sponsored by the Institute of Hospital Administrators and the journal The Hospital. A total of 100,000 square feet of space will be available to the exhibitors. The affair has become an important and highly

specialized event in its field; in 1959 there were 176 exhibitors and 25,000 visitors, including official representatives from nearly 70 different countries.

The exhibition is planned to run concurrently with conferences and lectures arranged by hospital organizations, such as the Institute of Hospital Administrators' annual general meeting and 3-day conference; the Institution of Hospital Engineers' annual general meeting and 3-day conference; the National Association of Hospital Supplies Officers; the Society of Hospital Laundry Managers; the Chartered Society of Physiotherapists; the Guild of Public Pharmacists; and the Hospital Caterers' Association.

Housekeeping Course Given by A.H.A.

A course in hospital housekeeping, sponsored by the American Hospital Association, is to be presented April 3 to May 25 at Michigan State University, East Lansing, Mich. The course is designed to provide practical training in hospital housekeeping procedures for executive housekeeping staffs and prospective employees. Enrollment is limited to 40 persons.

The course includes the philosophy of hospital care and institutional organizations; personnel management; institutional management; and housekeeping supplies, equipment and procedures.

Registration blanks should be sent to the Course in Hospital Housekeeping, Kellogg Center for Continuing Education, Michigan State University, East Lansing, Mich.

Therapy Unit Opened

A physiotherapy and occupational therapy unit has been opened at the Assiniboine Hospital, Brandon, operated by the Sanatorium Board of Manitoba.

The modern, one-storey therapy unit will provide an up-to-date physical medical service for the hospital's 170 extended treatment patients. It will also include treatment facilities for persons outside the hospital who can benefit from rehabilitation medicine.

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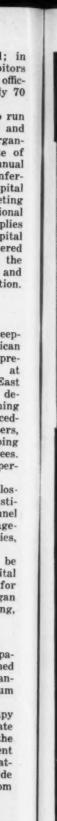
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The unusual temperature requirements specified for the new Illinois Psychiatric Institute presented an extraordinary challenge for John Dolio & Associates. This Chicago engineering firm was asked to provide an absolutely uniform temperature throughout the 11-story, T-shaped building. Because temperature variations cause extreme discomfort—even pain—to mental patients, the system had to be accurate, foolproof and automatic. Because Chicago temperatures rise or fall to extremes within hours—sometimes minutes—the system had to be capable of sensing the changing weather picture outside and automatically and simultaneously reacting inside.

The resulting design provides all the answers . . . in a Powers pneumatic control system that operates automatically 24 hours a day—every day—at a bare minimum of cost; a system that compensates instantly for sudden outdoor temperature changes; a system that can be checked and controlled by one man.

The result is a functional system of control where practical engineering principles were combined by the Dolio firm with a strong helping of ingenuity in order to whip some of the more unusual problems. For example, since chilled water was to circulate through ceiling heating-cooling panels, a safeguard against condensation was necessary. The engineers solved this problem with a series of dew point controls mounted at various locations in the ceilings. Thus, "controls on a control" prevent water temperature from falling to the point at which condensation could occur.



h-O-Matic Control Panel with

Illinois Psychiatric Institute.

Phil Derrig, Chief Mechanical Engineer of the Dolio firm, inspects one of the dew point controls specially designed to prevent condensation of cold water in the ceiling heating-cooling panels.

Pulowers Temperature Control To Work go'Veather At Illinois Psychiatric Institute

Illinois Psychiatric Institute Chicago, III.

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Architects:
Shaw, Metz & Associates, Chicago
Associate Architects and Engineers:
Fugard, Burt, Wilkinson and Orth
Consulting Engineers:
John Dalio & Associates, Chicago
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JOB DETAILS

The system encompasses 12 temperature zones, each designed to operate independently in relation to individual zone exposure problems. Ten zones utilize ceiling heating and cooling panels at which hot and chilled water circulate from zone exchangers. Three-way control valves for the water are modulated by pneumatic thermostats in various rooms. Two zones — auditorium and stairwell — have only heat exchangers (the auditorium is supplied with individual conditioned air).

Master outdoor controls sense the changes in temperature outdoors and instantly reset submaster pneumatic thermostats at the zone exchangers. These indooroutdoor controls are engineered for foolproof maintenance of uniform zone temperatures.

A central control board, the heart of the Dolio design, monitors the complete heating, cooling and ventilating system. The building engineer alone can instantly

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Temperature controls are inaccessible to patients.

All controls in the corridors are wall-mounted and cabinetenclosed; temperature sensors are mounted in ceiling exhaust ducts.

Easy servicing and low maintenance are two big reasons why a pneumatic system of control was specified by this engineering firm. Efficiency at low cost is characteristic of this type of control — as it is with the Powers pneumatic system installed here.

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Male Auxiliary Aids Hospital

The Solar Club, an all male auxiliary, has presented the Queen Elizabeth Hospital, Montreal, P.Q., with a complete audio-visual unit for conferences, teaching and clinical diagnosis. The unit, consisting of a film projector with accessories, slide projector and screen, is worth \$1,500, and will be used by doctors in studying the techniques employed in experimental operations and in diagnostic work.

The Solar Club was founded 30 years ago by doctors of the then Homeopathic Hospital. It originally consisted of doctors of the hospital alone, but now includes business associates, and it has modified its rôle to enable it to raise funds for scholarships and equipment.

WA Opens Coffee Bar

The newest project of the Women's Auxiliary of the Lachine General Hospital, Lachine, P.Q., is the "Coffee Cup" which operates in the hospital for the use of visitors, patients and staff. Manned and operated by volunteer workers, it is open seven days a week. The auxiliary is at present conducting a membership campaign.

Metropolitan Women to Buy Projector

Plans to purchase a movie projector with a loudspeaker attachment for use in the school of nursing were announced by the Women's Auxiliary of the Metropolitan General Hospital, Windsor, Ont.

The net sum of \$2,702.17 was reported raised at the summer fair. The executive will meet with the hospital administrator to decide the best use for this money. It will be used either to purchase new equipment or towards furnishing one or two rooms in the proposed new wing.

Auxiliary Makes Gift of Artificial Kidney

An artificial kidney, purchased at a cost of \$1,500, is the latest acquisition of Grace Hospital, Windsor, Ont., given by the Women's Auxiliary. The only one of its kind in Windsor, the machine will be available for use of all hospitals in the area. The first person to use the machine was actually a Metropolitan Hospital patient. Prior to its purchase, patients requiring

such treatment were transferred to Detroit.

New Service for Out-patients

The Women's Auxiliary of Victoria Hospital, London, Ont., has inaugurated a new volunteer activity - service to patients attending the out-patients' clinics. This new field of service was started on the suggestion of the hospital administration. Object of the out-patients' clinic service group is to bring cheer and comfort to clinic patients. At present this is being done by serving coffee and cookies on Monday and Thursday mornings, and the supplying of magazines to the clinic rooms. Clinics held these days have the largest attendance, sometimes ranging up to 100 per-

There are 33 clinics held each week at the hospital, covering 27 phases of the field of active and preventive medicine. It is the hope of the newly formed group of volunteer workers that they can expand their activities further in this broad field of service.

Auxiliary Donates Oxygen Tent

Oxygen tent and equipment for \$600 will be purchased for the Castlegar and District Hospital, Castlegar, B.C., by the Women's Auxiliary. The money was earned by the ladies at their thrift shop, through operating the service cart at the hospital, and through their annual nut drive held each year in November. The oxygen tent will be used to treat heart and asthma patients who live in the tent 24 hours a day and receive their meals through special panels in the tent which open and close with a zipper.

WA Presents Ice Making Machine

A major project of the Women's Auxiliary to the Kelowna General Hospital, Kelowna, B.C., was recently completed when the ladies gave the hospital an ice making machine valued at \$1,500. The machine which has a capacity of making 450 pounds of ice cubes per day meets a major need of the hospital.

Hospital Receives \$12,000

Donations worth close to \$12,000 were presented by the Women's Auxiliary to the St. Catharines General Hospital in the past year. Included in the donations were new x-ray and electrical equipment, an

electrocardiograph machine, two portable blood pressure machines and 36 fans. The drawing room of the Leonard Residence for Nurses was redecorated and refurnished complete with a piano and stainless steel cutlery. \$2,500 were donated to the hospital building and expansion program and an award of \$400 was set up to assist in the postgraduate training of an x-ray technician.

Surgical Instruments to Aid Missions

Surgical instruments for the Evangelical Medical Missionaries' Aid Society were donated by members of the Women's Auxiliary to the London Academy of Medicine. These instruments will be sent to such widely scattered places as Angola, Belgian Congo, Borneo, Ethiopia, India, Nigeria and the Philippines.

Bazaar Features Puppet Theatre

In its sixth year of operation, the Women's Auxiliary to the Toronto East General Hospital, Toronto, Ont., from the proceeds of its gift shop and the open house bazaar, has been able to fulfill its obligation to the building fund, furnish one wing in the renovated section of the maternity floor, and provide patient comforts with \$3,000 from its special projects fund.

The booths at the bazaar held towards the end of the year were bountifully stocked with hand-sewn and knitted garments, Christmas decorations (mostly hand-made), baby clothes, stuffed toys and a "nearly-new" hat and costume hat and costume jewellery bar. The main attraction of the bazaar was a puppet theatre featuring some fascinating puppets which were put up for sale after the show. Home-made jellies, jams and pickles and flower arrangements were also on sale. The gift shop had an abundance of very beautiful gifts for Christmas shoppers. For the many, interested in seeing the hospital, there were conducted tours.

International Tuberculosis Conference

The 16th International Tuberculosis Conference, under the auspices of the International Union Against Tuberculosis and the Canadian Tuberculosis Association, will be held from September 10-14, 1961, at the Royal York Hotel, Toronto, Ont. Further information can be obtained from the Secretary, Dr. C. W. L. Jeanes, 265 Elgin Street, Ottawa.



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Sterilization (continued from page 49)

cellaneous items—bone saws, microphones, x-ray film for placing in body cavities, incubators, cameras, anaesthetic and respiratory apparatus and various types of heart-lung machines (Bracken et al, 1960). Spencer and Bahnson (1958) described a suitable method for sterilizing a completely assembled pump oxygenator by means of ethylene oxide.

Deleterious Effects

Liquid ethylene oxide is somewhat more damaging than the gaseous form but here we are concerned only with the gaseous form, which may cause slight damage to some plastics.

Ethylene oxide has important effects on biological materials—it haemolyses red blood cells and there is evidence that it inactivates complement and prothrombin and reacts with certain proteins. On the other hand it may destroy the infectivity of viruses without any effect on their antigenicity.

Bacteriological media and experimental diets show an increased alkalinity after sterilization with ethylene oxide. The former showed no loss of ability to support the growth of micro-organisms but the latter failed to maintain the weight of rats.

Although some antibiotics can be sterilized without appreciable loss of activity others show a diminution in potency.

Advantages and Disadvantages
The advantages of ethylene oxide

sterilization seem to be as follows:
(1) few materials damaged; (2) good penetration; (3) effective at low temperatures; (4) effective at low humidity; (5) little residual effect; (6) lethal for all organisms including tubercle bacilli, spores and viruses; (7) very nearly as active against spores as vegetative organisms; and (8) wide variety of goods which can be sterilized with no damage including articles impossible to sterilize otherwise.

To be weighed against these advantages there are the following disadvantages to be considered:

(1) There are claims that sterilization is not in fact achieved by ethylene oxide on the basis of special bacteriological tests of some commercial equipment (Znamirowski et al, 1959) This may well be so, but it is equally plain from a considerable amount of published work that, provided that the right combinations of time, temperature, humidity and gas concentration are obtained, all micro-organisms tested can be destroyed. In any event the proof of the pudding is in the eating. In St. Mary's Hospital, St. Louis, Mo., an ethylene oxide sterilizer has been in continuous operation for two years and there has been no evidence of infection resulting from its use. Furthermore, when one considers the large amount of commercially available ethylene oxide sterilized plastic and surgical dressings used in hospitals and elsewhere, it seems plain that ethylene oxide is an efficient sterilizing agent. However, in view of the claims it would probably be wise to test ethylene oxide sterilizers bacteriologically on frequent occasions—every time it is used (Laskowski, 1960).

(2) Engineering Difficulties—there are claims that engineering difficulties are frequent. It is true that some pieces of equipment have given trouble initially but once this has been overcome apparently such difficulties are negligible compared with the financial saving which will be discussed below.

(3) Slowness—one disadvantage of ethylene oxide sterilization is that it is slow. This is quite true but is by no means insuperable. At present, it would be necessary to obtain sufficient apparatus to use during, say, 24 hours while another batch of appartus is being sterilized. This would allow plenty of time for adequate exposure to ethylene oxide, sufficient time subsequent to exposure for "airing" to ensure that all ethylene oxide is eluted from rubber and plastics, and, finally, time for preliminary results of bacteriological tests. It may be objected that the purchase of such additional equipment would be unduly costly, however, as will be seen below, ethylene oxide sterilization may result in considerable obvious savings. Furthermore it is generally agreed that anything tending to diminish hospital infection will result in financial saving.

(4) Special Equipment-another disadvantage is said to be that ethylene oxide sterilization demands special equipment. This of course is true but the same may be said for any new development. However, an ordinary autoclave chamber can be used. A preliminary vacuum is drawn and a small amount of steam is allowed to enter intermittently under controlled conditions to maintain the correct humidity. Ethylene oxide is readily available and is supplied to the chamber from tanks of the gas suitably diluted with an inert gas.

(5) Space Requirements — one further disadvantage is that for economical operation ethylene oxide sterilization requires a considerable amount of space: firstly, for the reception of goods to be sterilized including bulky items such as mattresses, pillows, blankets, incubators and so on; secondly, for holding the sterilized goods while they are "airing". In the unit at St. Mary's Hospital mentioned above, a little more than 1500 square feet were allocated to ethylene oxide sterilization. Thirdly, the sterilizer chamber it-

self would have to be larger to ac-

The Extension Course in Hospital Organization and Management

All those interested in enrolling in the 1961 class of the extension course in hospital organization and management should submit applications not later than March 31st. The course commences the middle of August. Because the demand for enrollment continues to be heavy, assurance can not be given that applications arriving late will be considered.

The two year program is now in its tenth year, and the certificate of graduation given by the Canadian Hospital Association has been granted to 435 persons. Those enrolled in the course spend eight months each year studying lessons at home and preparing assignments. This period is followed by an examination and a four-week intramural summer session at a specified Canadian university.

Information and application forms may be obtained by writing to: The Secretary, Committee on Education, Canadian Hospital Association, 25 Imperial Street, Toronto 7, Ontario.

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commodate bulky items such as mattresses and since the sterilizing period is a long one the chamber should be large enough for the routine requirements of one day.

(6) Cost — slowness of sterilization requiring extra apparatus, special equipment, space requirements and the cost of the gas make ethylene oxide sterilization more expensive than steam under pressure. On the other hand there are two considerable sources of saving that ethylene oxide provides. Firstly, surgeons' rubber gloves can be sterilized up to 30 times (Laskowski, 1960) without deterioration whereas in steam sterilizers they can be sterilized only four or five times and gradually becomes less elastic. It is estimated that in 500-bed hospitals about \$4,000 can be saved in a year if ethylene oxide sterilization is used for rubber gloves instead of steam sterilization. The second source of savings is in bedclothes (exclusive of sheets which are easily laundered): blankets that appear relatively clean may be permeated with large numbers of bacteria. Ordinarily, in some hospitals, such blankets are laundered or dry-cleaned after use by each patient. This results in damage to the blankets which are certainly not sterile. Ethylene oxide sterilization of blankets in plastic bags is cheaper and results in much less damage than either laundering or dry-cleaning, resulting in considerable savings.

(7) Inflammability—the inflammability of ethylene oxide presents no problem in equipment designed for hospital use since it is suitably mixed with an inert gas and may be handled quite safely with appropriate engineering safeguards.

(8) Toxicity—since the gas mixture is not flammable, it may be exhausted to the outside air and appropriate safeguards can be applied to prevent toxicity by inhalation. Toxicity from vesication by ethylene oxide passing on to the skin from such things as rubber gloves, plastics and so on may be avoided by ensuring an adequate "airing" period after exposure to the gas during sterilization.

Summary

It seems that the advantages of ethylene oxide sterilization far outweigh the disadvantages. In fact, ethylene oxide sterilization seems to be the answer to all the difficult problems of disinfection and sterilization that arise in hospitals today. Experience has shown that it

is efficient and will work in hospitals. Disadvantages can be countered by careful organization of the flow of goods to be sterilized and by awareness of the possible dangers. The expense of special equipment, space and the slowness of the process will be offset by savings in using the equipment to its fullest capacity on such things as gloves, blankets, mattresses and pillows.

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The author wishes to acknowledge the helpful discussions with Dr. the helpful discussions with Dr. J. J. Shull, bacteriologist to the Wilmot-Castle Company, Dr. L. F. Laskowski of St. Louis University School of Medicine, and Sister Mary Celeste, S.S.M. in charge of ethylene oxide sterilization at St. Mary's Hospital, St. Iouis, Mo.

Misused Terms in Architecture

"Functional, streamlined and decoration" are three words which should be deleted from the English language, architect Edward D. Stone told more than 500 members of the National Society of Interior Designers at a recent meeting.

"Functionalism has lost its luster. Everybody is satiated with glass and aluminum boxes. Probably nothing less functional has ever been contrived. Glass and metal are excellent conductors of heat and cold and transfer ideally the glare of the sun. Ever since the eave, these have been problems. Why attempt, in effect, to heat and cool all out of doors and create interior glare where smoked glasses are almost mandatory. It is a paradox upon paradox that these buildings are labeled functional."

"'Streamlining' is the sinful province of the industrial designer. Ever since the 20's when someone showed a photograph of an island of ice in a river, which the current of the water had given a tear drop or air-foil shape, we have been cursed with this obsession that everything is going somewhere in a hurry, whether it be a pencil sharpener, a fountain pen, a house frau's kitchen or a taxi cab."

"Decoration began a few decades ago, when Elsie de Wolfe picked up a few whimsical objects d'art for her friends and called herself an 'interior decorator' then the profession was born. And there no doubt are some who perpetuate the chi-chi, frou-frou tradition; but it is an injustice to call people 'decorators' who sincerely plan interiors that are useful, workable, and beautiful within a budget. Serious designers should be labeled interior designers," the noted architect feels.-Institutions, September, 1960.

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recent federal grants

Construction

From the speech from the throne, November 17, 1960: "With a view to avoiding any interruption in the building of urgently needed hospitals, it is deemed appropriate to announce now the intention of the Government to recomment to Parliament that the federal grants for hospital construction be continued for a further five-year period after the expiration of the present period in March, 1963."

The Toronto Western Hospital, Toronto, Ont., has received a grant amounting to \$32,100. The money will be used for the renovation of a large, open ward, to provide private, semi-private, and small

ward units.

The construction of a modern nurses' residence with accommodation for 14 nurses at the Niagara Peninsula Sanatorium, St. Catharines, Ont., will be assisted by a grant of \$9,800.

A grant of \$39,966 has been awarded to Mount Sinai Sanatorium, Ste. Agathe des Monts, P.Q. This sum will be used in new construction to modernize and relocate treatment facilities.

Construction of a new building which will provide quarters for the Matsqui-Sumas-Abbotsford Health Centre, Abbotsford, B.C., will be assisted by a grant amounting to \$15,000.

Improvement in hospital facilities in the Willingdon district in Alberta will be achieved with the assistance of a grant amounting to \$29,300. The new addition to the Willingdon General Hospital will provide accommodation for 27 patient and seven infant beds.

The first rehabilitation hospital in Manitoba will be established in Winnipeg, with the assistance of a grant amounting to \$639,600. Construction and operation will be under the supervision of the Sanatorium Board of Manitoba. The hospital will provide accommodation for 162 beds for rehabilitation and physical medicine; 20 beds for the diagnosis and treatment of tuberculosis; and it will also have an out-patient department for occupational and physiotherapy and hydrotherapy for up to 200 patients daily. It will also accommodate a school which

will offer a two-year course leading to a diploma in either occupational or physiotherapy.

A grant amounting to \$83,900 has been awarded the Outlook Union Hospital, Outlook, Sask., for the construction of a new hospital. When completed, hospital facilities will comprise 30 active treatment beds, one labour bed, one recovery bed and an eight-bassinet nursery. There will be an emergency out-patient treatment room and facilities for operating, case room and diagnostic services.

New accommodation for 129 nurses will be provided at the Ste-Croix Hospital, Drummond-ville, P.Q., with the assistance of a grant amounting to \$159,000. On completion of the new residence, the 60 nurses' beds now located in the hospital will be converted to

patients' beds.

Patient accommodation will be doubled at the Trenton Memorial Hospital, Trenton, Ont., upon the completion of the new additions. Construction will be assisted by a grant amounting to \$213,000. Approximately \$21,000 of this sum will be used toward the cost of renovating various sections of the existing hospital so as to improve services and bring them into line with those in the new wings.

A grant amounting to \$23,000 has been made available to assist in reconstruction and renovation at the Toronto East General and Orthopaedic Hospital, Toronto, Ont. The money will be used to provide improved kitchen facilities, service areas and enlargement of the pharmacy department.

For the first time the Georgetown and district area will be served with an entirely new hospital. A grant amounting to \$195,500 will assist in the construction of the project. The hospital will have accommodation for 66 patients, 5 recovery and four labour beds, a 22-bassinet nursery, an out-patient department, laboratory, pharmacy, an x-ray unit and a physiotherapy department.

Hotel-Dieu de Quebec, Quebec, P.Q., received a grant of \$269,135. The grant will assist in extensive renovation and modernization of the hospital including installation of a central kitchen, a central oxygen supply system for 195 beds

and re-grouping of several offices and departments.

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Construction of a new building containing space for a community health centre at West Kildonan, Man., a suburb of Winnipeg, will be aided by a health grant amounting to \$15,700. This building will be occupied jointly by the West Kildonan Health Unit and the West Kildonan School Board.

A grant of \$178,360 has been approved towards the cost of a new million dollar structure which will replace the obsolete facilities of All Saints' Springhill Hospital, Springhill, N.S. The three-storey building will have a total bed capacity of 68 and nursing accommodation for 18 babies.

Construction of a nurses' residence at the Elk Point Municipal Hospital, Elk Point, Alta., will be assisted by a grant amounting to \$7,500. Upon completion in June of this year the residence will accommodate 15 nurses of the hospital staff.

Additional accommodation for 10 active treatment beds at the Wakaw Union Hospital, Wakaw, Sask., will result with the assistance of a grant amounting to \$24,000. The extension will increase total capacity from 14 to 24 beds.

Completion of a community health centre at Natal, B.C., has been assisted by a grant of \$4,600. This centre will serve an area of some 400 square miles in the British Columbia portion of the Crow's Nest Pass.

A \$19,378 grant will assist St. Joseph's Hospital, Three Rivers, Que., in modernization of its kitchen and rebuilding of its interns' residence.

Establishment of a separate x-ray and laboratory section for the paediatric department of the Victoria Hospital, London, Ont., has been made possible with the assistance of a \$15,800 grant. These facilities will relieve the work load of the x-ray section in the main building and will improve service in the paediatric section.

The construction of a new nurses' residence by the Moosomin Union Hospital Board at Whitewood, Sask., will be assisted by a grant amounting to \$3,700. The new building will provide accommodation for five nurses, two doctors' offices and examining and waiting room facilities.

With the assistance of a grant amounting to \$303,200, a new sixstorey wing is being added to the Hotel Dieu Hospital, St. Catharines, Ont. When completed, active treatment bed capacity will be increased by 126 beds, raising the total accommodation to 281. The new wing will also contain a laboratory. Alterations to the existing building will provide for a new minor operating room and a pre-operative care room.

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Construction of a new 109-bed hospital to replace the earlier building of St. Joseph Hospital at Maniwaki, Que., will be assisted by a grant of \$269,900. When completed, the new building will provide for 103 treatment, 3 recovery and 3 labour beds, as well as a 24-bassinet nursery. Facilities will include obstetric, surgical, paediatric and medical departments. Quarters for 15 nurses will also be provided.

Research

The Hospital Division of Arberta's Department of Health is planning a survey of nursing care in the hospitals of that province, This three-phase study will look into standards, practices and staffing in Alberta hospitals. Recommendations are expected on educational requirements for staff, as well as staff requirements for the various sizes and phases of hospital operations. A grant of \$16,175 has been awarded toward the project's costs.

The place of home nursing in the health care services of a modern public health program will be studied by the province of Alberta in co-operation with the Canadian Red Cross Society in a three-year project in the county of Grande Prairie. A grant amounting to \$3,350 has been awarded for the current year towards this study.

Research in the field of basic medical sciences will be carried out at the University of British Columbia with the assistance of a grant amounting to \$35,100. The sum will be used for the provision of new equipment for the research centre at the university.

Education

Over 300 Quebec hospital administrators and accountants will attend a series of forums to consider the newly installed hospital insurance program. A grant amounting to \$14,400 has been allotted the Quebec government to assist in these conferences. The specific aim of the meetings is to explain to administrators and accountants how to handle the hospital forms and records which are essential for the operation of the hospital insurance scheme.



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Canadian Hospital

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New Method of Payment to Ontario Hospitals

As of January, a new method of paying public active treatment hospitals and hospitals for convalescents, has been introduced by the Ontario Hospital Services Commission. The payments are to be based on monthly portions of approved budgets rather than actual claims processed within a given month. It is hoped that this will help streamline payments for insured services to the advantage of all concerned.

This measure provides a solution to a resolution which was adopted by the Ontario Hospital Association at its last meeting and indicates the close co-operation between the two bodies.

Full details of the changes can be found in a brochure published by the Commission.

Logic

A young student when asked to define 'capital punishment', replied: "Capital punishment is when the government taxes you to get capital so that it can go into business in competition with you, and then taxes the profits on your business in order to pay its losses."



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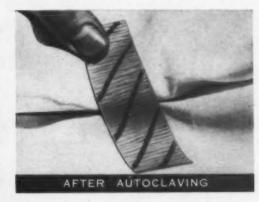
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Princess Margaret Hospital (concluded from page 41)

main ward block the wards are grouped in pairs on either side of a central area which contains stairs, lifts and accommodation which can be shared between wards.

The main hospital buildings consist, therefore, of a multi-storey ward block with extensive views straddling, at right angles, the single- and two-storey outpatients' and treatment departments and also the maternity and children's ward.

The buildings in stage 1 are in one- and two-storey blocks, and are mainly the diagnostic departments. They have been designed to allow for later alterations or extensions.

Small individual waiting areas are provided for each out-patients' clinic.—The Architect and Building News. United Kingdom Information Service.

A.C.H.A. Activities

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POLLOWING are some of the educational programs sponsored by the American College of Hospital Administrators for this year:

Feb. 20-24, University of Minnesota, Minneapolis, Minn.

Sept. 5-15, International House, Chicago, Ill.

Advanced Institutes:

Basic Institutes:

May 1-5, Second Canadian, Royal York, Toronto, Ont.

Aug. 14-18, 12th Chicago, A.H.A. Headquarters, Chicago, Ill. Dec. 4-8, First Northwestern

Multnomah, Portland, Ore.

Regional Members Conferences:

March 22-24, Region 16, Mac-Donald Hotel, Edmonton, Alta. July 10-12, Region 2, Belmont Plaza, New York, N.Y.

Nov. 6-8, Region 10, Leamington Hotel, Minneapolis, Minn.

Fellows Seminar:

Nov. 13-15, 15th Fellows Seminar, Princeton Inn. Princeton, N.J.

Preceptors Conference:

April 13-14, 9th Eastern, Belmont Plaza, New York, N.Y.

Orderly Trainee Program

For the past two years the University Hospital, Saskatoon, Sask., has provided a six month training program for orderlies. The main goal of the course is to make available a sufficient number of qualified orderlies.

The curriculum consists of a minimum of 96 hours of classroom instructions correlated with supervised practice in the wards. This formal plan, plus the rotation to all departments, followed by an assignment to an area, gives each trainee an opportunity to attain the objectives:

1. Gain an understanding of the role of an orderly in the hospital.

2. Learn the techniques and skills of patient care.

3. Increase in ability to perform

safely and efficiently. In April last year, eight candidates completed the course and seven are now on the staff at that

hospital. -Bulletin, University Hospital.

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Holds card just right to identify tray at a glance. Stainless steel, easy to keep clean and shining. Adds to service, costs very little. No. 9208.



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Administrative Audit Service Available in Ontario

An administrative audit service, modelled after the Management Audit Program of the American Hospital Association, is now available to hospitals throughout Ontario. The service will be provided by the Ontario Hospital Association to administrators free of charge and on request. Its primary aim is to give hospital administrators the benefit of an "outside" review of their organization by qualified persons.

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The audit consists of a complete review of the hospital as it is affected by the hospital board, medical staff, internal organization and all ancillary organizations associated with the hospital. The service involves a team from head-quarters' staff working at the hospital for approximately three to four days following which a written report is made available to the administrator.

The basis for introducing such a service rests on the fact that although the product of the hospital—patient care—is difficult to measure, the hospital organization, as such, can and should be periodically reviewed and assessed.

Addition Opened at General Hospital, St. John's

The new diagnostic and treatment wings at the St. John's General Hospital, St. John's, Nfld., were opened recently.

The total cost of the wings was \$2,250,000, which was paid for by the provincial government, with substantial grants from the federal government and the Cancer Society. Very extensive and modern facilities have been provided in the new wings.

One of the special features in the hospital are the facilities provided for the treatment of cancer—a tumor registry office for the recording and follow-up of all cancer patients in that province. A cobalt 60 bomb, located in a specially designed underground area, is accessible through the basement.

Institute on Community Education for Health

In conjunction with the national convention of the Canadian Public Health Association, an institute on Community Education for Health is being scheduled. The institute will be held at the University of Saskatchewan, prior to the C.P.H.A. convention, from June 2

to 5 and will reconvene in Regina after the national meetings, for a final study day on June 9. The major objective of the institute is to assess current concepts and techniques in the diffusion of health information and to develop a fresh approach to the understanding and educating of the public.

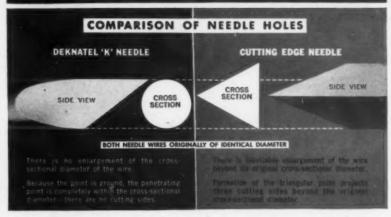
Enquiries or suggestions should be addressed to Dr. Robin F. Badgley, Department of Social and Preventive Medicine, University of Saskatchewan, Saskatoon.

Available

The 1960 Proceedings of the third Canadian Conference on Mental Retardation, held in Montreal, September 14 to 16, are available at the price of \$1 from the Canadian Association for Retarded Children, 317 Avenue Road, Toronto 7, Ont.

The Roman law said: "The safety of the people is the supreme law." But until we desire to live safely the law cannot be effective.

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Badge for Indian Health Services



With approval from the Queen, a badge has been created for the Indian and Northern Health Services. The badge will appear on the uniform worn by the public health nurse in the Service and also on parkas worn by field medical and nursing staff, and on I.N.H.S. blazers. Consideration is being given to the production of pennants using the badge to be flown under the ensign at I.N.H.S. nursing stations.

The purpose of the badge is to provide a symbol of the Service and to create a device which the Indians and Eskimos will come to recognize as symbol of help and understanding.

The idea of the badge and the symbols used in it were developed at I.N.H.S. headquarters in Ottawa, and the badge itself was executed

by Alan Beddoe.

The main element of this badge is a disc, blue in colour, encircled by a narrow gold frame. On the blue background appears a large white star of 16 points as in a Compass Rose, to symbolize North Star, upon which is placed vertically, pointing up, an Indian arrow in red, the arrow being entwined by a golden serpent, so that together this resembles a Rod of Aesculapius—the symbol of medicine. Below the disc are two branches of maple, tied together in base with a ribbon, all in gold. The whole design is surmounted by the Royal Crown in proper colours to signify that this is a branch of the government services.

Coverage for Home Care

The Associated Hospital Service of New York (Blue Cross) is extending its scope of benefits to cover care received in the patient's home, following hospitalization. At present benefits will be provided for up to 30 days at home, and this period may be extended in the near future. Services covered will include nursing (by visiting nurse agencies), physical therapy and social services when feasible, and laboratory services, drugs, dressings, x-rays and ambulance. Discharge to home service will be decided by the private physician, in line with criteria set up by Blue Cross and a home care council in each hospital. The local Blue Shield Plan is co-operating in the program by developing a payment formula for physicians' services which will carry over from hospital to home. The physician will receive the same fee as for a hospital visit.

Fund for Heart Research

A total of \$1,085,410 has been awarded for research in heart diseases during the past year by the Life Insurance Medical Research Fund. This brings the total contributions to more than \$12,500,000 since the fund's establishment in 1945.

The Life Insurance Medical Research Fund is supported by 138 member life insurance companies.



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Conference to Study Shortage of Physiotherapists

A conference to study ways of meeting the steadily increasing demand for professional physiotherapists will be held in Toronto on May 1, it was announced by Dr. J. S. Crawford, Conference Committee Chairman. The conference will be under the joint sponsorship of the Association of Canadian Medical Colleges, the Canadian Physiotherapy Association and the Canadian Association of Physical Medicine and Rehabilitation.

According to the Conference Planning Committee, a serious shortage of physiotherapists is already apparent in many parts of Canada. Unless steps are taken to increase professional training facilities, the committee believes that the provision of medical rehabilitation services necessary for the chronically ill and disabled will be seriously jeopardized.

During the one-day conference, some fifty invited representatives of university medical schools, the physiotherapy profession, government departments, voluntary agencies and hospitals will hear and discuss eleven separate papers dealing with the main features of this problem. These will include: the results of a survey of nearly 600 hospitals now being carried out by the Canadian Hospital Association; forecast of the numbers of physiotherapists required during the next five to ten years; plans for the extension of university training facilities and the advisability of establishing professional training for physiotherapists at centres other than universities.

Following the Conference, its findings will be combined in a report which the Conference sponsors expect will chart the developments which must take place if the supply of physiotherapists is to be brought into balance with the steadily increasing demand.

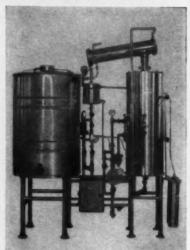
Members of the Conference Committee are: Dr. J. S. Crawford, chairman; Jane Hudson, Miss Mary Martin, Lawrence L. Wilson and Edward Dunlop, all of Toronto; Dr. Bruce Young, Kingston; William Allison, Ottawa; and Dr. Roger Dufresne and Mrs. R. H. Gault of Montreal.

For further information: Mary H. Martin, Conference Secretary, 900 Yonge Street, Toronto 5, Ont.

A pessimist is a gloomy person who passes all his days in constant expectation of the unexpected.

-English Digest

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Red Cross Offers Fellowship for Graduate Study

The National Nursing Committee of the Canadian Red Cross Society offers a second fellowship for graduate study in nursing or in one of the allied professions. Applications will be received until May 1, 1961, in order that an award may be made for the 1961-62 univer-

sity year.

The qualification of a given candidate should include professional maturity, registration in Canada, at least a baccalaureate degree and professional experience covering a period of not less than five years. Preferably, the preparation sought should be for a specific position available and accepted by the candidate. However, this does not rule out a situation where the actual conduct of a piece of research might, if under suitable auspices, constitute the process through which preparation could be obtained. The word research is used in its broadest sense and is not intended to set a standard beyond the needs which might be presented. Naturally, with but one national fellowship available, her sphere of influence would be a factor in the final selection of the candidate, as well as a desire to study at the doctorate level.

The amount of the bursary will, to some degree, be related to the needs of the candidate, within the limit of available funds. This matter is left open deliberately until more experience has been gained through a consideration of the needs of actual candidates.

Enquiries should be directed at an early date to the National Director of Nursing Services, Canadian Red Cross Society, 95 Wellesley St., East, Toronto, Ont.

Electronic Aids Cut Down Staff Work in Hospitals

Countless "doctor and nurse hours" are being saved as new inventions come into use in the hospitals and health services of the United Kingdom. While new heart machines, lung machines, artificial kidneys and other such medical marvels are constantly being developed to prolong life and reduce suffering, many other new devices from the nation's go-ahead electronics industry are being designed to lessen the labours and increase the efficiency of the busy matron and her hard-working nurses and ward maids, the house surgeon and his medical staff, the almoner and the office administrator.

A clinical thermometer has been perfected that can record the temperature of each patient in a ward at the same time. British manufacturers are producing new and improved equipment for automatic data processing to aid hospital management committees with their routine costing analysis and recording work. Digital computers may well be beyond the reach of individual hospitals but in big cities where many such institutions are serving the needs of a large area of population, their use

on a co-operative basis becomes an invaluable time and money saver.

Every hospital has its record maintenance problem. This can be solved by a new revolving drum record-card system, which is power-operated and available in several models with capacities ranging from 24,000 to 150,000 cards. The device incorporates a new arrangement for housing the cards, and as many as 6,000 can be brought within the operator's reach and vision with one movement.

Leontine Gay — courtesy of the United Kingdom Information Service.



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Professional Dietitian (continued from page 54)

However, the inadequate salary paid to senior dietitians in many hospitals makes it impossible for them to live in the community at the level of other professional persons. Thus, low salaries have an adverse effect on the status of the dietitian in the eyes of the public and this has indirectly affected recruitment.

(d) Limited opportunities in some hospitals for practising professionally. University graduates who are particularly interested in nutrition and diet therapy frequently find themselves in hospitals where the dietitians are overlooked by the medical team in discussions on dietary treatment. Often no effort is made by the medical team to discuss the diet or the feeding problems of the patient with her. Then if the patient does not co-operate the dietitian may be blamed. Such an attitude stems from lack of knowledge of the education and training of the dietitian and from lack of emphasis during the university or internship training of the physician on the value of nutrition and the psychological problems involved in feeding

On the other hand, many dietitians are so burdened with details of general administration that they are unable to give the necessary time to the more professional aspects of the job. The only solution to the latter situation is to organize the dietary department in such a way that routine matters are delegated, leaving the dietitian free to visit patients and consult with the medical team. Too many dietary departments are denied adequate secretarial or clerical staff by the administrator, so that the dietitians' time is spent in office or supervisory work which could very well be performed by an employee at the food supervisory or clerical level.

(e) Competition in recruiting dietitians. Career opportunities for women generally have increased tremendously in the past half century and are still increasing. Many careers now open to women require less education and less time spent in training, yet they pay as high if not higher salaries and involve less responsibility.

(f) Perennial loss through mar-

riage. Many dietitians leave the profession at the time when they could undertake positions of responsibility; this is a problem inherent in any professional group consisting mainly of women. The recruitment of men would assist in providing continuity in positions of responsibility but so far there has been no marked trend to this. Two main difficulties exist: the first is that the majority of university courses leading to careers in dietetics are basically home economics courses and these do not usually attract men; the second is that the generally low salaries offered in senior positions would not attract young men who could obtain better paid positions after a four year course in some other subject.

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Summary

An attempt has been made to draw to the attention of all concerned the critical situation facing hospital dietary departments. The following recommendations are made in an effort to assist both the dietetic profession and hospital administrators:

1. The administration and control of a hospital dietary depart-



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THE purpose of the Canadian Hospital Association library is to be of assistance to the personnel in Canadian hospitals. In addition to a fine collection of books, manuals, and pamphlets, the library maintains files of articles clipped from current journals on subjects pertaining to the various aspects of the hospital field. Packages are made up in accordance with specific requests. All material is available for a three-week loan period. There is no charge for this service. These packages are authorized as thirdclass matter and may be returned to the librarian at the rate of 2c for the first two ozs. or fraction thereof and 1c for each additional two ozs. or fraction thereof, or at the parcel post rate, at the option of the sender.

ment should be the sole responsibility of an experienced dietitian, assisted by a suitable number of qualified dietitians. Whenever dietitians are appointed to act only with respect to therapeutic diets the limitations of their rôles should be made very clear, so that they are not in any way held responsible for food service over which they have no actual control. An inexperienced dietitian who does not qualify as a professional dietitian should not be appointed as the only dietitian on the staff of the hospital.

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2. Since there is a serious shortage of experienced dietitians, administrators must realize that unless salaries are made commensurate with qualifications and responsibilities such personnel will be lost to better paid positions in competing organizations. Also, salaries paid at the successive levels of responsibility must be successively higher in order to encourage dietitians to continue in hospital dietetics and aim at the more senior positions. At the same time, beginning salaries must attract university graduates to enter hospital dietetics.

3. Smaller hospitals which cannot obtain the services of a fully qualified dietitian should seek the services of a dietitian on a consultant basis. However, such a hospital should not claim to have a fully organized dietary department or list the consultant dietitian as a full-time staff member. It is hoped that the government will expand its existing hospital consultant service to include fully qualified, experienced dietitians, who have previously managed dietary departments successfully. These would act as consultant dietitians with salaries commensurate with their experience and standing, so that all the hospitals in Quebec may have the help and guidance of competent dietitians.

4. The professional aspect of hospital dietetics should be strengthened by including dietitians as members of the hospital medical team as much as possible. The importance of nutrition in its preventive and curative rôles should be stressed in medical education, and dietitians should be given an opportunity to assist in this part of the program, so that their rôle in the hospital will be understood by medical personnel.

"The secret of success," said Disraeli, "is constancy to purpose."

Twenty Years Ago

From the Canadian Hospital February, 1941

Blackout of Hospitals

It would appear that hospitals as well as other institutions and buildings are having difficulty in en-forcing complete blackout. According to Hospital and Nursing Home Management, some matrons have adopted the course of warning nurses and their personnel that if the hospital offends, any member of the staff found responsible will be held personally liable. In the case of one large hospital the matron asked the authorities to deal seriously with the offending nurses as a warning to other members of the staff. The magistrate promptly gave the nurse a month's imprisonment.

Illegitimacy

Why should the illegitimate birth rate in Canada be almost twice that of the United States? Canada had 37 per 1,000 live births (1935 figures) while United States had but 20 (white population). However, the United Kingdom had 44, Germany 78 and Argentina (1938) 282 per thousand, One province of Argentina had a rate of 560 and a neighbouring territory 660 per thousand! In nearly all countries but particularly Germany the rate has increased.

An Unbroken Spirit

A significant notice was received from the London Fellowship of Medicine. The Honourary Editors of the Post Graduate Medical Journal regretted that owing to enemy action the January issue could not be published. But here is the British spirit: they anticipate combining this January issue with the February number.

Edmonton Hospitals Boost Rates

Acting on a resolution of the Alberta Hospital Association at its last meeting, Edmonton hospitals have increased per day rates, beginning January 1. Adult patient rates are increased by 50 cents per day and rates for children have gone up 25 cents. Hospital accommodation charges under the new schedule are: public ward, \$2.50; semi-public ward, \$3.00; semi-private, \$3.50 and \$4.00; private room, \$5.50.

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The Patient and P.P.C. (continued from page 33)

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thing which contributes to an atmosphere of a sick room, such as, bedpan, urinal, basins, and standards. Rooms should be private, with lavatory and bath facilities.

Much can be accomplished in this unit to assist the diagnostic patient to learn how to accept and handle his illness. For those recovering from illness, the unit provides a home-like atmosphere to give the patient emotional support prior to the return to previous environment.

Rehabilitation Unit

In this unit, patients recovering from cerebral-vascular accident, fractures which will hospitalize the patient for a long time, terminal cases, and confused elderly patients are placed.

St. John's Hospital, St. Paul, Minn., having established the intensive care unit and self-care unit in 1955 and 1956, erected a new addition for rehabilitation in 1958-59. A relaxing home-like atmosphere prevails in the unit and thought has been given to providing plenty of space for wheel chairs, ramps, and hand rails in the hallways.

Personnel in this area are specially trained in the techniques of rehabilitation such as positioning and use of self-help appliances, e.g., the use of the walker, crutchwalking and passive exercise. Staff must spend much time in teaching. Also associated with the unit is an occupational therapy department. Patients are encouraged to develop some manual skill that will be useful as a therapeutic measure as well as provide some remuneration upon return to the home environment.

Home Care or Extended Care

It is often recognized that patients who have progressed favourably while in a rehabilitation unit seem to backslide after return to their homes. Well-meaning relatives frequently over-indulge the patient to the point where there is a loss of the independence so recently achieved.

At St. John's Hospital, mentioned above, this problem resulted in the formation of an extended care service to form a fifth unit to the progressive care plan. A team which included a nurse, physiotherapist, and occupational therapist, went into the home to assist relatives to understand the patient's condition. Instruction was given in how to assist the patient with exercises or other supportive measures and, in some cases, referral of patients to other community agencies was arranged. This concept stirs the imagination to wonder if such a program in this country could not be wholly under the direction of an existing health agency.

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Although one or more aspects of progressive patient care have attained popularity in the United States and to a lesser degree in Canada, it is still very much in the experimental stage. It may be several years before the merits of such a plan can be evaluated as an over-all health plan.

Pharmacy Internship (concluded from page 42)

Sister Ruth Marie Hunter, a Sister of Charity of Halifax, Nova Scotia, holds a B.A. degree from Mount Saint Vincent College, Halifax, and taught school in Brooklyn, New York, Halifax, N.S. and Quebec City, Que. In 1960, she received her diploma in pharmacy from the Maritime College of Pharmacy, where the Sister was the recipient of the National Canadian Drugs Medal for highest standing in her

Upon receipt of a bursary from the Nova Scotia Department of Public Health, she obtained a year's leave of absence from the Halifax Infirmary to take the internship program, and will return to this hospital in July, 1961.

Internship Information

Expansion of the program to include two pharmacy interns is anticipated in the future.

Each eligible candidate should hold a B.Sc. in pharmacy degree from a recognized university, including at least one course in hospital pharmacy administration. Preference may be given to candidates who have previous experience in hospital pharmacy practice amounting to at least six months. Applications should be made in duplicate not later than May 1, on forms which may be obtained from the Secretary, Faculty of Pharmacy, University of Toronto. The date of application will be a factor in the selection of candidates. The program commences on July 1 of each year.

Medicine is in a continuous state of evolution . . . Every day is an experiment; nothing is errevocably settled; diseases which are baffling problems today may be conquered with ease tomorrow.

Sir Frederick Banting



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books received

THE ROYAL EDINBURGH HOSPI-TAL FOR SICK CHILDREN by Douglas Guthrie, Published by Macmillan of Canada, Toronto, O 1960. Pp. 75. Illus. Price \$3.00.

This little but entertaining volume describes the development of the Royal Edinburgh Hospital for Sick Children from a modest beginning a century ago to a position among the leading paediatric hospitals of the world. A chronological review is given of the hospital from the laying of its foundation to its present size and position with some thoughts included about the future.

The door of the hospital was opened on February 15, 1860, at which time only 12 patients could be admitted, but soon that number was doubled. A consulting room for out-patients was soon added with the resident medical officer attending the patients at home as well. Gradually the hospital expanded to its present size—three houses and in the future a fourth may well be added.

The foresight and imagination of the founders and of those associated with the institution through the years, as well as the generosity of the benefactors' contributions have helped the hospital attain the position it now holds-in treatment of children and in the training of paedetricians and nurses. Portraits of some of these people, as well as sites and activities of the hospital during its years of growth and service, have been included.

PLANNING NEW INSTITUTIONAL FACILITIES FOR LONG TERM CARE by Edna E. Nicholson. Pub-lished by G. P. Putnam's Sons, New York 1960. Pp. 358.

This book will be of great interest and help to the many concerned today with the problem of caring for the long-term patient. The planner, administrator, operator of nursing homes and the management personnel of other institutions caring for chronic patients will find the book of great assistance.

A detailed and informative study has been presented on the suitable construction and satisfactory op-eration of facilities required for the type of service under consideration. This study can be a helpful source of reference to the architect who must familiarize himself with all the phases of patient treatment, care and related needs before undertaking to design a hospital.

The author has presented a full analysis of the whole area of planning, administering, staffing and financing the facilities of the program. Miss Nicholson stresses the importance of co-ordinating the program with the activities of the whole community.

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The material in the book has been made possible as a result of a ten-year study, in which the author participated, conducted by the Institute of Medicine of Chicago.

ANATOMY AND PHYSIOLOGY FOR RADIOGRAPHERS, By J. E. Blewett, M.D., D.M.R., F.F.R., and A. M. Rackow, B.Sc., M.B., D.M. R.E. Published by Butterworth and Co. (Canada) Ltd., Toronto, 1960. Pp. 340. Illus. Price \$7.50.

The material in this book is based closely on the curriculum recently accepted by the Society of Radiographers. The aim of the authors has been to select and simplify those parts of many medical subjects which will give the radiographer a general background of medical knowledge comparable to that required of nurses or other medical auxiliaries. It is a completely practical work intended to give the radiographer a firm foundation in anatomy and physiology, to cover basic aspects of pathology and bacteriology, to enlarge her medical background and terminology, and to extend her knowledge in the care of patients.

PRINCIPLES OF HOSPITAL AC-COUNTING. By L. Vann Seawell, D.B.A., C.P.A. Published by the Physicians' Record Company, Berwyn, Ill., 1960. Pp. 360. Illus. Price \$7.50.

Written expressly for beginners, this book provides an ideal instruction medium for students, clerical workers, hospital department heads, trustees, administrators and others with no background or training in accounting procedures. The subject matter is presented logically and clearly, proceeding from fundamental principles and definitions to the preparation of complex financial reports.

While many shortcuts and simplified methods are presented, the book primarily helps to familiarize the reader with basic accounting principles. The function of records, bookkeeping, hospital purchasing, revenue, disbursements, expenses, payroll, depreciation, fixed assets, et cetera are covered in detail. There are questions and problems at the end of each chapter.

GOVAN FERGUSON LINDSAY KAMINKER LANGLEY KEENLEYSIDE

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MEMBER OF THE MERICAN HOSPITAL ASSOCIATION

Bursary Announced

St. John Ambulance in Canada has established a fund in memory of Countess Mountbatten of Burma, superintendent-in-chief of the St. John Ambulance Brigade in the Commonwealth and a vice-president of the Royal College of Nursing. The fund is to provide bursary assistance for nursing. The amount of the bursary will be \$600. The first award will be available this month. First consideration will be given to an applicant identified with St. John Ambulance. The bursary will be available to men and women and will apply to: assistance to student nurses, assistance for post-graduate study, and assistance in some special field of nursing. For further details, apply to the Chairman, Countess Mountbatten Bursary Fund, 321 Chapel St., Ottawa 2.

Rehabilitation Centre for Eskimos

A rehabilitation centre for handicapped Eskimos, situated on Baffin Island, was established by the Northern Affairs Department in 1957. In the past three years the centre has expanded considerably and extensive facilities have been provided for various projects. The centre was started to train Eskimos, returning from southern hospitals, to become self-supporting once again. After spending from months to years in a hospital, the Eskimo is not strong enough to return to his old way of life, that of living off the land - hunting and trapping.

Owing to the presence of a busy air base and the building of a new town, Frobisher Bay offers permanent employment opportunities for those who are unable to recover completely or who prefer the change, once they are trained in construction, carpentry, woodworking, mechanics and other trades.

The movie house, which is run by the Eskimos, is grossing more than \$1,000 a week, while the sale of handicrafts equals the income of the theatre. The rehabilitated Eskimo is living in a one-room cottage built by himself with lumber supplied by the centre. Today's Eskimo has most of the modern facilities in his home. Each unit has electricity and the radio is a favourite article.

The whole art of teaching is only the art of awakening the natural curiosity of young minds for the purpose of satisfying it afterwards. - Anatole France

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 25 Imperial St., Toronto 7, Ontario. Rates for classified advertisements are as follows:

\$3.75 per column inch of fraction thereof, minimum charge \$3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no advertisement charge, \$4 page display advertisement—\$25.00. Advertisements must be received by the first of the month to appear in that month's issue.

QUALIFIED TECHNICIAN

Male or female for Laboratory in 110-bed modern hospital. Must be well trained in all branches. Transportation paid to successful applicant.

Apply to:

Administrator **Western Memorial Hospital** Corner Brook, Newfoundland

Director of Nursing

Modern hospital with 42 adult beds and 11 bassinets has vacancy for Director of Nurs-

The hospital is located in a company operated town and serves a population of approximately 6,000. Community organized recreation. Residence accommodation and all conventional benefits available.

Salary range \$387.-\$507. per month, commensurate with experience and qualifications.

Apply giving particulars of training and experience to

Administrator,

ANSON GENERAL HOSPITAL

Iraquois Falls, Ont.

STAFF DIETITIAN REQUIRED

For a well equipped modern department in 532 bed teaching hospital.

Address enquiries to: Director of Dietetics, University Hospital, Saskatoon, Sask.

DIRECTOR OF **NURSING REQUIRED**

The Royal Alexandra Hospital is at present a 729 bed hospital which is expanding to 1300 beds. Salary is open depending on qualifications and experience. If interested please contact Dr. D. R. Easton, Executive Director, Royal Alexandra Hospital, Edmonton, Alberta.

DOCTORS' SUITE

Space available for two doctors or a doctor and dentist in new shopping centre located in growing suburban community in Metropolitan Toronto, Phone or write W. H. Clark, 76 Collier Street, Toronto 5, WAlnut 5-4588.

DIETITIAN

Applications are invited from qualified Dietitians to head Dietary Department of modern 110-bed hospital, expanding to 225 beds, Excellent conditions, residence accommodation if desired. Transportation paid.

Apply to:

Administrator Western Memorial Hospital Corner Brook, Newfoundland

MEDICAL RECORDS

To supervise Department in 110-bed modern hospital. Excellent opportunity and working conditions. Transportation paid.

Apply to:

Administrator

Western Memorial Hospital Corner Brook, Newfoundland

ASSISTANT DIRECTOR

Applications are invited for the position of Assistant Director—Nursing Services, University Hospital, Saskatoon, Saskatchewan, a 550 bed hospital situated on the Campus. University preparation desirable.

Apply to:

Director of Nursing Services, University Hospital, Saskatoon, Sask.

CHIEF DIETITIAN

(Replacement due to retirement)

Hospital 750 beds

Apply:

Administrator,

The Queen Elizabeth Hospital,

HOSPITAL ADMINISTRATOR

required to assume position of Administrator of Cornwall General Hospital. New construction presently underway expanding the hospital by 48 beds to a total of 250. Immediate appointment is desired, and all applications will be acknowledged and treated in confidence. These should be addressed to:

Mr. J. L. Cook, President,
Board of Governors,
c/o Cornwall General Hospital
and marked "Personal."

Edmonton General to Expand

The Edmonton General Hospital, Edmonton, Alta., owned and operated by the Grey Nuns of Montreal, is to build a new wing providing 220 new patient beds and 34 bassinets. The plan will involve tearing down temporary frame buildings and abandoning 103 beds in use at this time, The estimated cost of the addition is \$2,500,000. This will be financed in part by a building reserve fund and by construction grants. Upon completion, the hospital will have a total of 488 beds and 103 bassinets.

ASSISTANT DIRECTOR

Applications are invited for an Assistant Director of the Extension Course in Nursing Unit Administration. This course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association.

Qualifications: University preparation in teaching and supervision is necessary with several years experience in a supervisory position. Fluency in the French Language is desirable but not necessary.

For further information write to:

Director, Extension Course in Nursing Unit Administration, 25 IMPERIAL STREET, TORONTO 7, ONTARIO.

Host to C.S.L.T, Convention

The Manitoba branch of the Canadian Society of Laboratory Technologists is host to the 25th annual convention of the society to be held in Winnipeg, at the Royal Alexandra Hotel, from June 12 to 16. The tentative program appears to be very attractive and is planned to appeal to varied interests in the field of medical technology.

The Trend is Towards Self-Service

A Texas architect, who specializes in hospital design believes that atmosphere and surroundings in a hospital can help patients to get well. Self-service should be used as much as possible to encourage and prepare patients for a quicker recovery. Within easy reach of the bed is a thermostatic control so that patients can adjust room temperature and air-conditioning. They can even turn a dial to brighten or dim room lights to suit their needs or moods. Each bed is placed adjacent to a specially built bedside unit, which contains a closet, dresser space, a sink and mirror, telephone outlet, thermostat, and a two-way communication system to the nursing station.

Poison Control System Established in Alberta

A Poison Control Service in all hospitals has been established by the Alberta Department of Public Health. All hospitals have been equipped with an index system listing 2,400 common household substances containing toxic chemicals. The treatment and antidote for each is contained on the reference card. The necessary instruments and equipment for treatment have also been provided.

At Edmonton and Calgary, Central Poison Information Centres have been located to supply hospitals with information and treatment on additional lesser known poisons. A direct telephone line to all treatment centres will immediately make available the service of the information centre.

Making a comprehensive record of all cases of poisoning in the province is also part of the plan.

Careless

Friend—"In your business, doctor, you can't afford to make mistakes."

Doctor — "You're telling me! Once I carelessly cured a millionaire in three visits."

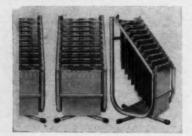
SUPPLIERS TELL US-

Interesting items from the news releases of hospital suppliers

By C.A.E.

Beam Metal Chart Racks Incorporate New Ideas

Chart racks with a "new turn" are in production at Beam Metal Specialties, Inc. The Beam-Matic Chart Rack revolves in its own diameter of 13 inches, It makes charts accessible from either side of the desk as well as from any angle.



The rack is all aluminum of tubular construction; anodized finish with 360° turntable action. Made in two sizes to accommodate standard 9" x 12" chart holders or longside hinge 12" x 10" chart holders.

Other models are available.

Please write Beam Metal Specialties, Inc., 25-11 49th St., Long Island City, N.Y.

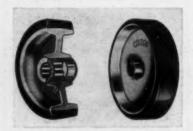
Colson Dynathane Wheels Offer Many Advantages

Dynathane wheels, developed after two years of extensive laboratory and field tests, have been introduced by The Colson Corporation, manufacturers of a complete line of industrial and institutional material handling equipment.

During the test period, Colson engineers found dynathane to far out-perform other standard materials. In addition to dynathane's durability and strength characteristics, this new polyurethane material offers maximum rollability even after hours of remaining in a set position, and a closer tread-to-wheel bonding.

Unlike conventional urethane wheen construction, Colson has designed its dynathane tread around an aluminum wheel containing a specially designed ridged center

for permanent bonding strength. The aluminum wheel also has been proved to be highly resistant to corrosion, offers high tensile strength, and results in a 30 percent weight reduction compared to iron core.



Because of dynathane's unique qualities, The Colson Corporation has made its non-marking urethane material available on its pressweld and forgeweld caster lines.

Write to Colson (Canada) Limited, 65 Manser Road, Weston, Ontario.

Linen Inspection Station Developed by MacBick

The MacBick Linen Inspection Station affords a uniformly illuminated work surface on which gowns, drapes, pack-wrappers and other such surgical linen can be inspected for pin holes, tears and the like.



Sylvania and Corning engineers worked closely with MacBick designers to develop the shadowless inspection panel. Users have extolled the time-saving and inherent security of linen-inspection on this improved station.

Work surface flanges and edges are white Formica; apron is white Formica with front surface attractively interrupted with natural birch panel; ends are protected natural birch panels. Vertical uprights of chrome-plated squaretubing frame are equipped with adjustable feet.

Over-all dimensions are 72"L x 36"W x 37"H.

The station is equipped with recessed switch, rapid-start ballast, and 6'-0" detachable electric cord with female receptacle at table end and male plug at outlet end; 110V, 60 cycle, A.C.

Full particulars available from The MacBick Company, Cambridge 39, Mass.

Illuminated Clipboard for Writing in the Dark

A new illuminated clipboard, providing ample light for note-taking, writing, or reading instruments in any inadequately lighted room is a boon to residents, interns, nurses, research lab workers, and students.



The "Write-in-Lite" Illuminated Clipboard, manufactured and distributed by Clay-Adams, Inc., uses ordinary flashlight type bulbs and easily replaceable standard size D batteries. Constructed of long-lasting, tough masonite (9 x 14½), the Clipboard is coated with an attractive glossy, scratch-resistant, light gray plastic finish.

The steel lamp housing is finished in matching gray hammertone. For further information write to Clay-Adams, Inc., 141 East 25th St., New York 10, New York.

"Operating Room Newsletter" Offers Aid to Nurses

A new, informative bulletin, called "Operating Room Newsletter", was recently introduced by The Pioneer Rubber Company, makers of Rollpruf, Quixam and Nimble Fingers aurgical and medical glove products.

ORN, with six issues scheduled per annum, has been created to

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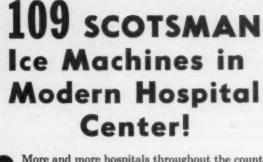
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SUPER FLAKER above is one of 109 Scotsmo Ice Machines supplied to six Memphis hospitals by Memphis Automatic Ice Machine Co. Note handy waist-high bin and free-flowing ice flakes.



More and more hospitals throughout the country are modernizing their ice supply systems with automatic Scotsman Ice Machines. Take Memphis, Tennessee, for example. In the six modern hospitals pictured, you'll find 109 Scotsman Ice Machines making pure and perfect ice conveniently available at the point of actual ice use . . . and with 24-hour-a-day dependability! Many other leading hospitals, both large and small, now employ the Scotsman System for a modern and economical ice supply.



St. Joseph Hospital

John Goston Hospital





University of Tennessee Medical Center

La Bonner Medical Center



Methodist Hospital

Wouldn't your hospital, too, like to get the full facts about Scotsman?



SCOTSMAN dernize with Modern Ice!

CE MACHINES



YES! Please send complete details, including new "Ideas on Ice" booklet on Scotsman Ice Machines,



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CITY

ZONE STATE

Mail to: SHIPLEY CO. OF CANADA LTD., Rexdale Blvd., Toronto, Ont. or, TAYLOR-PEARSON-CARSON, 1000 Richard St., Vancouver, B.C.
UNITED REFRIGERATION, 223 Garry St., Winnipeg, Men.

Suppliers Tell Us— (continued from page 92)

serve as a clearing house for information that will help in the better performance of operating room duties. This unique, "Get Acquainted" vehicle offers nurses an opportunity to share experiences on new techniques, equipment, procedures and recurring operating room problems.

Each issue contains a postagefree reply form on which the readers are invited to jot down their questions and mail them directly to the editors. The queries received are carefully analyzed and, whenever possible, grouped according to subject matter. A new selection is made for each issue from the most recently submitted.

To obtain accurate, first-hand knowledge, the Newsletter editors adopted a unique format. A rotating panel system—with new panel members selected for each issue—is comprised of qualified ORN's who have been nominated by their fellow-nurses. These panelists act as an advisory board offering their answers to queries submitted by readers. This method assures direct and complete resolutions to existing problems which occur in the daily routine of operating room activities.

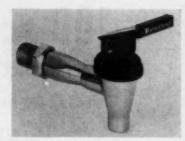
In announcing the new publication, Pioneer general sales manager, J. R. Jones, stated: "The exchange of information through the medium of a roundtable discussion in print will, we believe, provide help for operating room staff members on all levels."

Operating room nurses who would like their names placed on the list to receive issues of the "Operating Room Newsletter" can send their requests directly to Margie Beamer at The Pioneer Rubber Company, Willard, Ohio.

Self-Closing Faucet New Product by Barnstead

Barnstead Still and Sterilizer Co., announces the development of a new faucet designed for both self-closing and non-self-closing operation. A two-sided handle closes faucet on release or keeps it open depending on side used.

Effective silicone plunger eliminates dripping. Faucet is constructed of rugged, break-resistant plastic and nylon. All materials coming into contact with the distilled water are inert for purity protection. The manufacturer states



that three models are available: Nylon, Tin-coated, and Tin-lined.

Write Barnstead Still and Sterilizer Co., 171 Lanesville Terrace, Boston 31, Mass., for further information.

Hobart Dual Speed Slicer Has Many Uses

The Hobart Dual Speed Automatic Slicer features solid cast stainless steel knife, high and low speed selector and spiral gear drive. The automatic drive can be converted to manual feed.



For slicing meats (hot or cold) fowl, fish, cheese, breads, fruits, and vegetables, this more versatile slicing machine comes with interchangeable food chutes and adjustable fences which permit random slicing use in production, and handles items up to 12'' in width or $7\frac{1}{2}''$ in diameter.

Easy accessibility is provided for cleaning the entire machine, including both sides of the knife. Manufacturer is The Hobart Mfg. Co. Ltd., Toronto 2.

B-D Offers Series of Lectures on Sterilization

A comprehensive booklet containing eight authoritative articles on the subject of sterilization procedures and controls is being distributed by Becton, Dickinson and Company.

The 123-page booklet is a compilation of the Becton, Dickinson Lectures on Sterilization presented as part of the curriculum in bacteriology at Seton Hall University College of Medicine and Dentistry. Lecture topics were the problems of sterilizing surgical equipment, heat, gaseous and chemical sterilization methods, the control of cross infection, skin antisepsis, new horizons in sterilization and the control of sterilization procedures.

Lecturers were: Lawrence P. Garrod, M.D., F.R.C.P., Professor of Bacteriology, St. Bartholomew's Hospital, London; John J. Perkins, M.Sc., Director of Research, American Sterilizer Company; Charles R. Philips, Ph.D., Chief, Physical Defense Division, U.S. Army Chemical Corps; Earle H. Spaulding, Ph.D., Professor and Head, Department of Microbiology, Temple University School of Medicine.

The booklet is now being sent, as a service by B-D, to hospital administrators and other personnel concerned with sterilization, to medical schools and to schools of hospital administration. Additional copies are available and will be sent on request by writing to Becton, Dickinson and Company, Rutherford, N.J.

D. B. Strike Restores Asphalt Tile Floors

Damaged or faded asphalt tile floors can be safely restored with D. B. Strike, the latest development of Dustbane Mfg. Co. Limited. Damage and colour fading, it is stated, can be corrected even when it appears replacement of the flooring is the only answer.

For details write Dustbane Mfg. Co. Limited, 88 Metcalfe St., Ottawa.

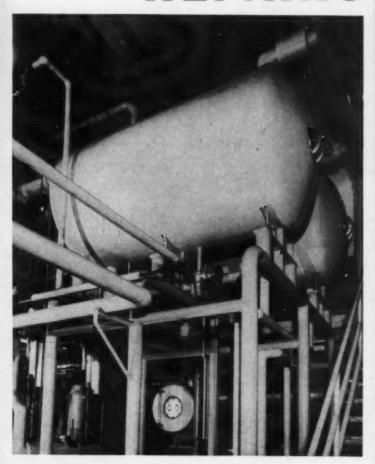
O. E. M. Shows New Model of Cof-flator

A new and greatly improved model of the Cof-flator was shown at the recent meeting of American Association of Inhalation Therapists. This unique instrument stimulates the coughing function in those who have lost their cough reflex or who, through paralysis, are unable to rid themselves of secretions and mucous. This instrument, which has had widespread clinical use in hundreds of hospitals, has been made much more compact and easier to transport. It also provides precise controls on pressures, volume and time eveling.

Designated as the "Model 81", the new Cof-flator is recommended for use in atelectasis, bronchial asthma, bronchiectasis, respiratory

(continued on page 96)

20 YEARS WITHOUT REPAIRS



PROOF THAT MONEL*
HOT WATER STORAGE TANKS
LAST LONGER, CUT REPAIR
AND MAINTENANCE COSTS

Replacing a large hot water storage tank—usually in a cramped location—is often extremely difficult and invariably expensive. That's why it's important to install a tank that will last! And a Monel tank does just that! The tank shown here has been in operation 10 years without repairs... a comparatively short time for a Monel tank. Many such tanks have been giving trouble-free service for over 20 years.

This is because Monel is a nickelcopper alloy that is ideal for hot water storage tanks. Monel is highly resistant to the corrosive effects of water at high temperatures, and withstands most of the common corrosive conditions encountered in service.

You can depend on Monel for lasting, trouble-free service. When you consider the savings in repairs and maintenance—even replacement costs—you can see why you'll be farther ahead with a Monel tank in your operation. For specific information and advice on your hot water storage and heater requirements, consult:

Ellett Copper & Brass Co. Limited Vancouver, B.C.

Darling Brothers Limited Montreal, P.Q.

Ferro Metal Ltd.

Toronto, Ont. and Montreal, P.Q.

The Arthur S. Leitch Co. Limited Toronto, Ont.

Reliance Welding Works, Limited Edmonton, Alta.

INTERNATIONAL NICKEL

COMPANY OF CANADA, LIMITED

SS YONGE STREET, TORONTO



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Suppliers Tell Us— (continued from page 94)

interruption, emphysema, poliomyelitis and cases of paralysis from brain stem damage.

The unit is housed in a convenient to carry case, the dimensions of which are $19'' \times 13\frac{1}{2}''$ and $8\frac{3}{4}''$. The weight is 32 lbs.

A 12-page booklet is available which describes the use of this unique device. Manufactured by Shampaine Industries, Inc., O. E. M. Division, East Norwalk, Conn.

Ralph Falk II Chairman of Baxter Board

Ralph Falk II has been elected chairman of the board of Baxter Laboratories, Inc., to succeed his late father, Dr. Ralph Falk, company founder who died Nov. 2. Dr. Falk's widow, Mrs. Marian Citron Falk, was also elected a director of the company at a special meeting of the board of directors.



Ralph Falk II

Mr. Falk has served Baxter Laboratories in a number of capacities since 1939. Starting as a production worker that year, he later held a variety of manufacturing posts and for two years was plant manager of the company's Cleveland, Miss., operation. He is administrateur of Baxter Laboratories of Belgium, S.A., and before assuming his most recent post as senior vice-president, he was president of Baxter Laboratories of Canada, Ltd.

Onan Appoints New Sales Manager in Canada

Mr. T. C. Arnold, of Montreal, Quebec, has been appointed zone sales manager for Onan Products in Canada, according to an announcement by Roy E. Mullin, vice president, marketing, of the Minneapolis firm. Mr. Arnold will be responsible for sales of all Onan products in the following eight provinces: New Brunswick, Newfoundland, Nova Scotia, Manitoba, Prince Edward Island, Quebec, Ontario and Saskatchewan.



T. C. Arnold

As Zone Manager, "Chris" Arnold will work closely with Onan distributors and dealers, and deal directly with manufacturers and with provincial and the federal government of Canada. His background includes 10 years of diversified experience in manufacturing, engineering and sales in the electrical and associated industries.

Mr. Arnold holds a B.A. Sc., and M. Comm., from the University of Toronto; an M.B.A. from the U. of Western Ontario, and is a lecturer on Industrial Management, in the Extension Dept., McGill University.

Onan products include Gasoline and Diesel Electric Generating Plants, Air-Cooled Engines, Engine-Driven Compressors, Separate Generators and Controls,

New Battery Powered Intercom Systems

Philips Appliances Ltd., Toronto 17, announces the introduction of two new Intercom Systems.

A Multiple-Unit System includes a master station with push-button operation, signal lights and five sub-stations.

Features include light weight—2¾ lbs. for master unit; 1¾ lbs. for sub-station; adjustable volume control; sub-stations can be secret or non-secret; only two wires required for each station. The capacity of the master station can be extended for 10 or 20 sub-stations.

Of special interest to small institutions is the new single unit system which includes single station master unit and one substation complete. The unit can be easily installed, as only two connecting wires are required. No electric power is required.

Brochure available on request.

Edwards of Canada Appoint Earland M. Dawson

Edwards of Canada Limited, Owen Sound, Ont., announces the appointment of Earland M. Dawson, B. Sc., P. Eng., as Chief Engineer.

Mr. Dawson, a graduate of the University of Alberta, joined Edwards in 1953 as electrical engineer. Since that time he has served Edwards in a variety of positions in their engineering, marketing and operations divisions.



E. M. Dawson

R.C.A. Victor Appointment in Alberta

B. R. Machum, manager of technical products marketing for RCA Victor Company, Ltd., has announced the appointment of R. B. Lanskail as manager of technical products marketing in Alberta.

For the past seven years, Bruce Lanskail has been technical products marketing manager in the Ottawa office of RCA Victor. In his new position he will be based in Calgary and will be responsible for marketing the Company's full range of technical and industrial products in the Province of Alberta. These include Keleket x-ray equipment, radio and television transmission and studio equipment.

Bruce Lanskail is very well known in the West for he first joined the Company, in 1935, as service manager for British Columbia, After five years service as Signals Officer in the RCAF, he rejoined RCA Victor in 1945 and was appointed sales engineer for the engineering products division, in B.C.

(concluded on page 98)

NOW REPRESENTED IN YOUR AREA BY FISHER & BURPE

Gorman-Rupp Industries'

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Patent No. 2866072





Automatic "Hot Water Bottle" — The right heat, accurate to within 1°F., hour after hour, day after day, even week after week! A flexible vinyl pad with sealed channels and a control unit which circulates water at prescribed temperatures.



Bedside Control Unit — Sensitive thermostat, illuminated temperature dial. Sealed heating element. Hermetically sealed, whisper-quiet pump. Off-on switch. Removable selector key. One-pint, clear plastic reservoir.



For Sprains, Bruises, Bursitis, Arthritis

— Easily laced into place, light weight, flexible. The pad is securely and comfortably in place. Fits the body's contours without hampering patients movements.



For Cooling Applications, Too—Room temperature: set dial at "cool", effects moderate cooling. Sub-room temperatures: set dial at "cool"; coil tubing in basin of ice; provides rapid cooling.



Moist Heat for Inflammations — Comfortable, light in weight, not bulky. Evaporation reduced by constant and uniform heat. Checking of hot compresses reduced to a one-in-six-hour procedure. For phlebitis, arthritis and similar ailments.

IN USE IN OVER

Designed to avoid dangerous burns. Saves up to 86% of nurses' time. For more information on this safer therapeutic unit, ask your man from Fisher & Burpe.



Suppliers Tell Us— (concluded from page 96)

Appointed Manager of Corning Canadian Plant

John H. Cole has been appointed manager of the Leaside, Ont., plant of Corning Glass Works of Canada.

Cole succeeds A. Russell Arnold, who has been named assistant to the manufacturing manager of the consumer products division of Corning Glass Works at Corning, N.Y.

The Leaside plant processes Corning Ware, a line of cookserve-freeze utensils made of the high-strength glass-ceramic, Pyroceram.

The facility also serves as a warehouse and distribution centre for several other Corning products, including Pyrex brand cook ware, television bulbs, and glass products for science and industry. The latter include items imported from Great Britain and distributed by Corning.

Cole has been with Corning Glass Works since 1951. He has served as an industrial engineer, process engineer, and, since 1956, as production superintendent of one of the company plants in Corning, N.Y. He holds a bachelor of science degree from Columbia University.

Automatic Electric Appointment on Industrial Sales

Mr. S. C. Bird, vice-president and general manager, Automatic Electric Sales (Canada) Limited, has announced the appointment of W. D. Bishop as sales representative, industrial sales.



W. D. Bishop

Mr. Bishop will specialize in the sales of TelAutograph telescribing equipment and in industrial closed circuit television systems. He will be located in Toronto.

Lalonde "Silent Gearless" Floor Maintenance Machine

Illustrated is the Lalonde concentrated-weight Silent Gearless Floor Maintenance Machine, available in 7 models from 12" to 32" and from 34 to 1½ H.P. It can be used for carpets, or any type of scrubbing, waxing, polishing, buffing, steel wooling, sanding, grinding, trowling and finishing terrazzo and cement floors.



There are no costly gears to strip, rattle, wear or drip oil. Oilite life packed bearings are sealed for life. This is truly a skilfully designed machine. Various auxiliary attachments available. For colour catalogue sheets and full information, contact the manufacturer, The Frank P. Lalonde Ltd., 5977 New Metropolitan Blvd., Pointe Claire, Que.

Brave New World?

According to the electrical industry we can expect some day:

A miniature television screen for telephones which will permit you to see the person with whom you are talking.

A home television camera which will take family movies to be shown on your own closed TV circuit.

Cold light, providing light without heat and almost without shadow.

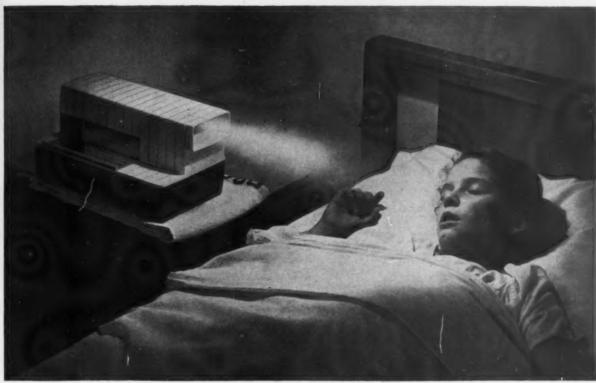
Closed circuit television which will allow a mother to keep close watch on her children.

Electronic translation, permitting persons with no knowledge of each other's language to converse by telephone.

Electric highways, along which cars will drive themselves automatically, using radar.



WHITE MOP WRINGER COMPANY OF CANADA, LTD., PARIS 3 , ONTARIO



Compact, portable Crospaire delivers a penetrating "fog stream" of cool, healing vapor directly to the patient . . . without need for mask or canopy.

for refreshing, deep hydration of the respiratory tract

cool-vapor humidifier

Your patient recuperates in comfort while the compact Croupaire delivers a directional "fog stream" of cool, micronized vapor for deep hydration of the respiratory tract.

By hydrating the respiratory mucosa, soothing moisture relieves thirst and dryness so annoying to post-tonsillectomy and other post-surgical patients.

In croup and other acute respiratory disorders, the Croupaire moistens the sticky exudate which accumulates in the lumen of the bronchioles so it may be loosened and coughed up. A comfortable environment of cool humidity promptly eases breathing.

Croupaire operates quietly from any A.C. outlet, and provides continuous cool-vapor therapy for about 10 hours without refilling.

Croupaire therapy in your hospital will help speed recovery after anesthesia, tracheotomy, tonsillectomy and other surgical procedures; and ease breathing in croup, bronchitis, pneumonia, bronchial asthma and other respiratory disorders.

Used as a room humidifier, the Croupaire also helps prevent coughs and colds resulting from dried out air in winter-heated hospitals or homes.

Electronic research and engineering to serve medicine

AIR-SHIELDS CANADA. LTD.

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EM. 4-8634

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